Maternal and Child Health Services
Title V Block Grant

State Narrative for Idaho

Application for 2009
Annual Report for 2007

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services and are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Last year Idaho contracted with Health Systems Research to conduct Idaho's 5 year needs assessment. This process included input from various organizations and individuals representing MCH populations. The process included written and phone surveys, focus groups and key informant interviews. See attached needs assessment. In addition to soliciting comments from the general public, members of the Needs Assessment Advisory Committee were asked to review and comment on this year's application. MCH funded programs involve public input as appropriate for program direction and implementation. For example, CSHP's ongoing effort to transition the program from a pay for service to a systems development and maintenance program. The program has coordinated numerous meetings with policymakers, advocates, health care providers and families to begin designing a system that will assure access to specialty health care for CSHCN. Public input will be solicited as we develop strategies to address the priority areas identified in the needs assessment.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ As a result of the 2005 MCH Needs Assessment, the following priorities were identified:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for women and children across provider and community networks.

2. Perinatal Depression. The reorganization of the Department of Health and Welfare resulted in a new division, the Division of Substance Abuse and Behavioral Health.

3. EPSDT Screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring appropriate.

4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.

5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex needs of all CSHCN.

6. Cultural Competency. Division of Health Administrator, Mrs. Jane Smith, RN, is recognizing "Centers of Excellence" within the Division.

7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.

8. Health Education: Strengthen health education in the public schools, including strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing sytem collaboration efforts that focus on outcomes for the MCH population.

10. Overweight and Obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children.

A number of factors over the past year have greatly influenced Idaho's MCH Title V program and the state priorities that were identified in the 2006 application. Below is a list of state priority areas that currently reflect the need of Idaho's MCH population. These are not in priority order; they are presented as a list of 7 key areas needing attention.

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.

2. Public Health will work with Medicaid to explore options to maximize services to the MCH population.

3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.

4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2

years of age.

5. Work with Medicaid, the newly formed Division of Behavioral Health and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.

6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.

7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy.

These seven priority areas encompass the overarching issues and recommendations of the Assessment to strengthen collaborative efforts, system development, collection, review and use of meaningful data and infrastructure building. The priority areas were defined by the Division of Health Administrator, the MCH Director, and the Division of Health Special Projects Coordinator. Data such as immunization rates, as well as existing systems, organization and personnel were considered in selecting the priority areas. The seven areas reflect the areas of need identified by the Assessment for Idaho's MCH program to work on in order to best serve all facets of the MCH population. //2008//

III. State Overview
A. Overview
Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and unhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Southern cities follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

Population Information

The 1999 estimated population for Idaho is one million, two hundred fifty-one thousand, seven hundred (1,251,700). Idaho ranks 40th in the United States in population. The increase from 1990 to 1999 of 24.3% was the third highest increase in the nation, after Nevada (50.6 %) and Arizona (30.4 %). This population gives Idaho an average population density of 14.7 persons per square mile of land area. However, 19 of Idaho's 44 counties are considered "frontier," with averages of less than six persons per square mile. In 1990, the national average for population density was 69.4 persons per square mile.
/2004/ The 2001 estimated population for Idaho is 1,321,006.

/2005/ The 2003 estimated population for Idaho is 1,366,332. Idaho ranks 38th in the United States in population. The increase from 1990 to 2003 of 35.7% was the fifth highest increase in the nation. This population gives Idaho an average population density of 16.26 persons per square mile of land area. Seventeen (17) of Idaho's counties are considered "frontier."//2005//

/2008/ The 2006 estimated population for Idaho is 1,466,465 which is a 13 % increase over the 2000 census. This gives Idaho an average population density of 18 people per square mile. The U.S. average is 85 people per square mile. Fifteen of Idaho's 44 counties are considered "frontier" with fewer than 6 people per square mile. //2008//

The physical barriers of terrain and distance have consolidated Idaho's population into seven (7) natural regions with each region coalescing to form a population center. Approximately 72% of Idaho's population reside within 25 miles of one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 28% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties. /2005/ 34.38 percent of the population in Idaho reside in the rural areas of the state.//2005//

/2005/ Summary of Population by Region (Health District) for 2000
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 250,984 19.40

District 2 100,533 7.77
District 3 191,297 14.78
District 4 344,355 26.61
District 5 162,397 12.55
District 6 156,906 12.13
District 7 160,132 12.38

/2005/ Summary of Population by Region (Health District) for 2003
(April 1, 2000 Census)

DISTRICT POPULATION PERCENT
District 1 265,672 19.44
District 2 100,348 7.34
District 3 213,465 15.62
District 4 369,002 27.01
District 5 167,444 12.26
District 6 158,266 11.58
District 7 168,969 12.37
//2005//

/2007/ Summary of Population by Region (Health District) for 2005
(July 1, 2005 Census Estimate)

DISTRICT	POPULATION	PERCENT
District 1	201,570	14.1%
District 2	100,465	7.0%
District 3	227,825	15.9%
District 4	389,228	27.2%
District 5	170,617	11.9%
District 6	162,342	11.4%
District 7	177,049	12.4%

//2007//

/2007/ Summary of Population by Health District for 2006
Idaho Population Estimates, July 1 2006

District	Population	%
Idaho	1,466,465	
1	206,140	14.1%
2	101,195	6.9%
3	237,246	16.2%
4	403,626	27.5%
5	173,626	11.8%
6	163,022	11.1%
7	181,610	12.4%

Source: Census Bureau, Internet release March 22, 2007. //2008//

/2009/
Population Estimate July 1, 2007
Source: Census Bureau, Internet release March 20, 2008

District	***Population Count***	***%***
Idaho	***1,499,402***	***100.0***
1	***208,445***	***13.9***

2 102,388 6.8
3 243,156 16.2
4 418,778 27.9
5 174,057 11.6
6 162,880 10.9
7 189,698 12.7
//2009//

Ethnic Groups

The estimated racial groups that comprised Idaho's population in 1999 were: (a) white, 96.9%; (b) black, 0.60%; 8 native American/Eskimo, 1.33%; (d) Asian/Pacific Islander, 1.15%. Hispanics make up 7.4% of the race categories. More than half of Idaho's Hispanic population resides in two regions (health districts), with 32.5% residing in Health District 3 and 20.4% in Health District 5. The majority of the Native Americans resides on four reservations in northern and eastern Idaho in Health Districts 1, 2, 3 and 6 and number an estimated 16,320.

/2007/ Population Estimate, July 1, 2004
Percent of Total Population Estimate in District by Race and Ethnicity

		Race				Ethnicity
	Total			American	Asian and	
		White	Black	Indian	Pacific Islander	Hispanic or Latino*
Idaho	100.0%	96.4%	0.7%	1.6%	1.3%	8.9%
District 1	100.0%	97.2%	0.4%	1.9%	0.6%	2.5%
District 2	100.0%	94.6%	0.5%	3.5%	1.3%	2.1%
District 3	100.0%	97.0%	0.6%	1.2%	1.1%	18.1%
District 4	100.0%	95.6%	1.3%	0.9%	2.3%	5.8%
District 5	100.0%	97.9%	0.5%	0.9%	0.7%	16.7%
District 6	100.0%	94.7%	0.6%	3.8%	0.9%	8.2%
District 7	100.0%	97.9%	0.6%	0.7%	0.8%	8.0%

*Persons of Hispanic or Latino ethnicity may be of any race and are included in the appropriate race totals.

Source: National Center for Health Statistics. Estimate of July 1, 2004 resident population from the Vintage 2004 postcensal series by state, county, year, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; Internet release September 9, 2005.//2007//

/2009/
July 1, 2006 Estimate by Race and Ethnicity*
Idaho Districts and Counties

	RACE				***ETHNICITY***	
	White	***Black***	***American Indian***	***Asian or Pacific Islander***		
RESIDENCE		***TOTAL***				***Non-Hispanic Hispanic***
IDAHO		***1,466,465***	***1,410,951***	***12,681***	***22,909***	***19,924***
1,327,595	***138,870***					
(percent)	***96.2%***	***0.9%***	***1.6%***	***1.4%***	***90.5%***	***9.5%***
District 1	***206,140***	***200,128***	***843***	***3,808***	***1,361***	***200,146***
5,994						
(percent)	***97.1%***	***0.4%***	***1.8%***	***0.7%***	***97.1%***	***2.9%***

District 2	***101,195***	***95,163***	***658***	***3,637***	***1,737***	***98,690***	***2,505***	
(percent)	***94.0%***	***0.7%***	***3.6%***	***1.7%***	***97.5%***	***2.5%***		
District 3	***237,246***	***229,617***	***2,037***	***2,908***	***2,684***	***193,081***	***44,165***	
(percent)	***96.8%***	***0.9%***	***1.2%***	***1.1%***	***81.4%***	***18.6%***		
District 4	***403,626***	***384,133***	***6,175***	***3,722***	***9,596***	***377,825***	***25,801***	
(percent)	***95.2%***	***1.5%***	***0.9%***	***2.4%***	***93.6%***	***6.4%***		
District 5	***173,626***	***169,795***	***754***	***1,679***	***1,398***	***142,540***	***31,086***	
(percent)	***97.8%***	***0.4%***	***1.0%***	***0.8%***	***82.1%***	***17.9%***		
District 6	***163,022***	***154,375***	***1,108***	***5,877***	***1,662***	***148,769***	***14,253***	
(percent)	***94.7%***	***0.7%***	***3.6%***	***1.0%***	***91.3%***	***8.7%***		
District 7	***181,610***	***177,740***	***1,106***	***1,278***	***1,486***	***166,544***	***15,066***	
(percent)	***97.9%***	***0.6%***	***0.7%***	***0.8%***	***91.7%***	***8.3%***		

**** Race and Hispanic origin are reported separately. Persons of Hispanic origin are included in appropriate race totals.***
Data on two or more races available upon request, see Technical Notes for information on bridged race estimates.
Source: Bridged Race Population Estimates, National Center for Health Statistics, estimates of the July 1, 2006, United States resident population from the Vintage 2006 postcensal series, prepared under a collaborative arrangement with the U.S. Census Bureau, Internet release date August 16, 2007.
//2009//

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, the Migrant Health Branch, U.S. Department of Health and Human Services, estimated that over 119,000 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain. /2005/ A study of migrant and seasonal farm workers is currently being conducted. The report should be complete by Spring 2005. //2005//

Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are slightly below the national average. The three-year average (1997-1999) median income in Idaho ($36,023) was 9.2% lower then the national average ($39,657). The number of children under 18 living in poverty varies greatly by county from the lowest (9.1%) in Blaine County to highest (31.2%) in Shoshone County. The statewide average is 16.5%. Between 1985 and 1990, the proportion of Idaho children living in poverty decreased. However, since then there has been no further improvement despite a strong economy, increase in per-capita income of 19% between 1990 and 1994, and a decline in the percentage of single-parent families with children. For the three-year average (1997-1999), there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated poverty level. It is estimated that 53,000 of these children come from households that lack health insurance.

/2005/ Census data for 2000-2002 indicates there are approximately 393,000 children under the age of 19 living in Idaho. Approximately, 165,000 reside in households earning incomes at or below 200% of poverty level. It is estimated that 35,000 of these children come from households that lack health insurance.//2005//

/2009/ In 2005, 45% of all Idaho children lived in families with incomes below 200% FPL or $40,000 annual income for a family of four. This compares with a national rate of 40%. The statistics are worse for children under age five (48%) and Latino children (75%) living in low-income families. In 2005, 28% of children lived in low-income, working families which earns Idaho a ranking of 45th in the nation. Approximately 17.5% of all idaho children, 0 to 18 years of age, live below the FPL of $20,000 annual income for a family of four. //2009//

Educational Information

The percent of enrolled 12th graders who graduate from high school increased from 88.3% in 1993-94 to 91.1% in 1995-96; and remained stable at 91.1% in the 1998-99 school year. Idaho's 1999 - 2000 school dropout rate among 16-19 year-olds dropped to 6 percent.

/2005/ Idaho's 2002-03 dropout rate among 16-19 year olds dropped again to 3.88 percent. //2005//

/2007/ In 2004, 36.6 percent of people in Idaho 18 to 24 years of age have completed high school (including equivalency). In 2004, 87.3% percent of people 25 years and over in Idaho had completed high school (including equivalency) ranking Idaho 18th.//2007//

/2009/ In 2004 an estimated 30% of 3 to 4 year olds in Idaho attended a preschool program compared to a national rate of 45%. Idaho is one of only 10 states that does not provide a state funded pre-kindergarten program. Idaho does not provide any state funding for Head Start. Approximately 31% of the eligible population of 3 to 4 year olds in Idaho receive Head Start services. Minimally, 10% of Head Start / Early Head Start enrollment is reserved for children with special needs. During the 2006 -- 2007 program year, 606 Idaho children with special needs were served through Head Start / Early Head Start. //2009//

Health Delivery System in Idaho

As a frontier state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance for program implementation, planning health care systems and infrastructure. Serving distinct populations such as migrant/seasonal farm workers, children with special health problems, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting their livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery is comprised of the following elements:

A. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems.

/2007/ Statewide care coordination is provided for uninsured CSHCN through a contract with St. Luke's Regional Medical Center's Children's Specialty Center. Monthly pediatric and quarterly adult CF clinics are held at St. Luke's, and metabolic clinics are held quarterly at the state laboratory in Boise and twice annually at two district health departments. //2007//

/2009/ Statewide care coordination is provided for uninsured CSHCN through a contract with St. Luke's Regional Medical Center's Children's Specialty Center. Monthly pediatric and quarterly adult Cystic Fibrosis clinics are held at St. Luke's. Genetics clinics are held three days per month, and metabolic clinics are held three days per quarter, at State facilities in Boise. Regional metabolic clinics are held four times per year in northern and eastern Idaho. CSHP also provides financial support for quarterly cleft lip & palette clinics in Northern Idaho, and for several (more than one per month) clinics in Eastern Idaho serving patients with a variety of birth defects. //2009//

B. The Idaho Department of Health and Welfare, Division of Health, assists the district health departments by formulating policies, providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas.

C. In 2000, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,082. /2005/ Bed capacity has increased to 3,326.//2005//

D. There are 23 Community and Migrant Health Centers in Idaho which served 59,823 patients in 2000 with 213,241 encounters. There also are 35 certified rural health clinics, and 5 registered free medical clinics.

/2005/ There are 24 Community and Migrant Health Centers in Idaho which served 64,714 patients in 2002 with 234,101 encounters. There also are 43 certified rural health clinics, and 7 registered free medical clinics.//2005//

/2007/ There are 10 Community and Migrant Health Centers (organizations) in the state, but many of them have satellite clinics. It is perhaps more accurate to say there are 10 Idaho organizations serving 34 communities (including three communities in Oregon). The 330 grantees aggregately served 88,932 patients in 2005, with 329,228 total encounters (this includes medical, mental health, substance abuse and dental). It also includes 9,255 encounters for "enabling services" (case managers, health educators).//2007//

/2009/ Idaho is served by twelve Community Health Centers with over thirty-three clinic sites that offer primary and preventive care. Dental and mental health behavioral services are also offered at many of these locations. In 2006, Idaho's Community Health Centers served the medical requirements of over 92,000 patients. //2009//

E. As of March 2001, there were 2,290 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 182 physicians providing patient care per 100,000 population. As of April 2001, there were 1,208 primary care physicians in Idaho. The ratio of primary care physicians per 100,000 population is 96.

/2006/ As of May 2005, there were 685 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice, General Practice, Obstetrics, Gynecology, Ob-gyn, Pediatrics and General Internal Medicine as their primary specialties.) There were a total of 308 Physician Assistants, 29 Certified Nurse Midwives, 441 Nurse Practitioners and 1,073 Pharmacists licensed and practicing in the state. It is also practical to note that there are 254

licensed Community Pharmacies in Idaho. There were 810 Physical Therapists, 297 Occupational Therapists (and 98 Occupational Therapy Assistants), 57 Psychiatrists and 687 Dentists licensed and serving Idahoans. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2006//

/2007/ As of May 2006, there were 1,170 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice 592, General Practice 31, Ob-gyn 140, Pediatrics 131 and General Internal Medicine 276 as their primary specialties.) There were a total of 352 Physician Assistants, 21 Certified Nurse Midwives and 289 Nurse Practitioners. There are approximately 1,700 Pharmacists licensed with the State of Idaho, 1,400 of whom are practicing in the state. It is also practical to note that there are approximately 250 licensed Community Pharmacies in Idaho. There were 846 Physical Therapists, 316 Occupational Therapists (and 98 Occupational Therapy Assistants), 96 Psychiatrists and 716 General Dentists licensed and serving Idahoans, and 884 total licensed Dentists in Idaho. There are 882 active-status licensed Dental Hygienists in Idaho. These numbers represent whole counts made available through State Licensure Boards, and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2007//

/2009/ As of May 2008, there were 1,203 primary care practitioners licensed and practicing in Idaho (these include practitioners who list Family Practice 584, General Practice 28, Ob-gyn 142, Pediatrics 142 and General Internal Medicine 307 as their primary specialties.) There were a total of 441 Physician Assistants, 24 Certified Nurse Midwives and 511 Nurse Practitioners. There are 1,835 Pharmacists licensed with the State of Idaho practicing in the state. It is also practical to note that there are 274 licensed Community Pharmacies in Idaho. There were 902 Physical Therapists, 221 Physical Therapy Assistants, 357 Occupational Therapists (and 103 Occupational Therapy Assistants), 99 Psychiatrists and 789 General Dentists licensed and serving Idahoans, and 947 total licensed Dentists in Idaho. There are 1,081 active-status licensed Dental Hygienists in Idaho. These numbers represent whole counts made available through State Licensure Boards and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.//2009//

F. There are five Indian/Tribal Health Service Clinics operating in Idaho in 2000. These clinics provide a wide variety of preventive health services to Native Americans.

/2009/ There continues to be five Tribal Health Service clinics operating in Idaho. There is a clinic serving each of the federally recognized tribes in Idaho. Each of these tribes is also a delegate to the Northwest Portland Area Indian Health Board. //2009//

G. Health Maintenance Organization (HMO) penetration rate for Idaho is estimated at 7%.

An area of concern facing Idaho is its aging health professional workforce. Ranked one of the "oldest" in the nation (second only to Wyoming), the state's population is growing at a much faster rate than the health care professional workforce in primary care. Doctors and dentists are retiring more quickly than medical graduates are replacing them. Idaho does not have a medical or dental school to contribute to this much needed workforce.

Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. An estimated 17% of the state's population, over 205,700 individuals, have no health insurance. Forty-seven percent (47%) of Hispanic adults reported having no insurance and 21% of Native American adults were uninsured. For the three-year average 1997 - 1999, there are approximately 395,000 children under the age of 19 living in Idaho. Of these, approximately 181,000 reside in households earning incomes at or below 200% of the federally designated

poverty level. Most of those children below 200% are covered by some form of health insurance; however, approximately 29.3% (53,000), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 58,418 children under 18 who did not have health insurance in 1998. According to FY 2000 BRFSS survey data, 13% of Idaho households contained uninsured children.

/2005/ An estimated 16.8% of the state's population, over 225,600 individuals, have no health insurance (age 18-64, 2002 BRFSS data.) That equates to 1 out of every 6 adults not having health care coverage.//2005//

/2009/ In 2006, 18.8% of adults 18 years and older in Idaho had no health care insurance. The majority (58.9%) of Hispanics in Idaho were without health care coverage. This compares with 15.5% of non-Hispanic Idahoans. Those without health insurance coverage were more than five times as likely as the insured to say they needed to see a doctor in the past year but could not because of cost (43.8% compared with 8.5%). //2009//

Utilization of Medicaid is very low in Idaho compared to the rest of the nation. Less than 9% of Idaho residents are Medicaid recipients, compared to 12.6% of the U.S. population enrolled in Medicaid. Additionally, the 1998 Idaho State Child Health Plan Under Title XIX for the State Children's Health Insurance Program estimated that only about 60% of children eligible for Medicaid in Idaho are actually enrolled in the program.

/2005/ Many communities in Idaho, especially those in rural and frontier areas, are considered underserved. Idaho ranked 49th in the country in 2002 for number of primary care physicians per 100,000 civilian population. As of 2002, the ratio of primary care physicians per 100,000 population was 68. Currently 80.6% of the state's area has a designation as a health professional shortage area in primary care, 74.3% in dental health, and 100% in mental health (Figures 1, 2 and 3). Access to care in rural areas is especially variable. Providers are usually clustered in small communities but care for residents whose homes are scattered over large geographical areas. The problems are exacerbated by a shortage of health personnel, health workforce recruitment challenges, deepening fiscal problems of rural health care facilities, as well as by fragile EMS systems that often serve as first encounter points for direct care. Poverty level and low-income populations face exceptional problems in accessing primary care. An estimated 16.8% of the adult population (age 18 to 64, 2002 Idaho BRFSS data) does not have health insurance, and even more are considered to have "insufficient coverage". An estimated 45% of Idaho adults age 18 to 64 do not have dental insurance (2002 Idaho BRFSS data). Other barriers include language, cultural, transportation and geographic factors.//2005//

/2006/ Currently, 88.4% of the state's area has a designation as a health professional shortage area in primary care, 88.7% in dental health, and 100% in mental health (Figures 1, 2 and 3).//2006//

/2007/ According to the Morgan Quitno Press, Health Care State Rankings 2006, Idaho ranked 50th for "rate of physicians in 2004" with 193 per 100,000 population. Idaho ranked 49% for "rate of physicians in patient care in 2004" with 161 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2005" with a reported 17.9%. Currently, 90.0% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.9% in Dental Health, and 100% in Mental Health.//2007//

/2008/ According to the Morgan Quitno Press, Health Care State Rankings 2007, Idaho ranked 49th for "rate of physicians in 2005" with 198 per 100,000 population. Idaho ranked 49% for "rate of physicians in patient care in 2005" with 162 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2006" with a reported 18.0%. Currently, 95.3% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 92.4% in Dental Health, and 100% in Mental Health.//2008//

/2009/ According to the CO Press, Health Care State Rankings 2008, Idaho ranked 49th for "rate of physicians in 2006" with 200 per 100,000 population. Idaho ranked 49th for "rate of physicians in patient care in 2006" with 162 per 100,000 population. Idaho ranked 10th in "percent of population lacking access to primary care in 2007" with a reported 16.9%. Currently, 96.7% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 93.9% in Dental Health, and 100% in Mental Health.//2009//

The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. As a result, services such as those provided for reproductive health through contracts by the Title V agency are provided in only 37 (occasionally 38) of the 44 counties in Idaho. The counties without services are the most isolated and those with the lowest populations such as Camas county, population 844, and Clark county, population 906. Providing services to frontier counties that have clinic sites is challenging. For example, staff must travel from Idaho Falls (Bonneville County) to Salmon and Challis, Idaho, (Lemhi County) once a month to provide clinic services. This is a 368 mile journey that requires three nights of motel expenses, four days per diem expenses, and 7 to 10 travel hours. All travel is on two lane roads, and driving conditions are often hazardous in winter.

/2007/ According to the July 2005 population estimates, U.S. Census Bureau, the population of Camas County is now 1,050 and the population of Clark County is 943. Camas County now has services in Fairfield. Clark County does not have services.//2007//

There are 23 community/migrant clinic sites in Idaho. All but one is in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. /2004/ There are now 2 community/migrant clinics in north Idaho.

/2005/ There are 24 community/migrant clinic sites in Idaho. All but three are in southern Idaho. In 2000, they served 59,823 persons with 213,241 encounters. Seventy percent (70%) of their patients had incomes below 200% of poverty. Idaho also has 35 certified rural health clinics and 5 registered free medical clinics. There are now 2 community/migrant clinics in north Idaho.//2005//

/2007/ The Bureau of Facility Standards lists 47 certified rural health clinics. There are nine free medical clinics registered with the State of Idaho.//2007//

/2005/During 2003, two new community/migrant dental clinics opened in southwest Idaho and a third added a dentist. In north Idaho, one such dental clinic has been expanded and efforts are underway to establish dental clinics at the two new community health centers. A mobile dental clinic, with 1-2 dentists providing care onsite has been operating in north Idaho in partnership with the District Health Department. During 2003, 7,600 patients were served via 18,000 dental visits at 7 onsite community health center dental clinics staffed by 7.5 FTE dentists. As of November 2003, there were 10.6 FTEs with 2 vacancies.//2005//

Oral Health

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. Through the Children's Health Insurance Program (CHIP) outreach efforts, 29,829 children have been enrolled in Medicaid and CHIP since November 1999, bringing the total to over 90,000 as of April 2001. These children will likely have poor access to dental services because in 1999, only 27.9 percent of the enrolled children had a dental visit or service. The picture does not get any brighter with an American Academy of Pediatrics' estimate that an additional 55,000 to 75,000 children in Idaho are medically uninsured. The Surgeon General's Report on Oral Health in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance.

/2007/During SFY 2005, there were 104,041 children enrolled in Title XIX Medicaid for at least one month of the year and another 12,458 children enrolled in the Medicaid expansion Title XXI CHIP A and CHIP B.//2007//

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-three of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of March 2001, there were 709 active licensed dentists statewide. During state fiscal year 2000, the toll-free Idaho CareLine averaged 388 calls per month from persons seeking a Medicaid dentist. From July 2000 through February 2001, the CareLine received 4,061 calls for a Medicaid dentist and another 150 calls from persons seeking free or reduced fee dental services. In December 2000, CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 94 dentists responded that they were.

/2009/ During SFY 2007, the toll-free Idaho CareLine averaged 234 calls per month from persons seeking a Medicaid dentist, down 19 percent from 2006. Calls totaled 2,812 seeking a Medicaid dentist and 792 persons called seeking free or reduced dental services.//2009//

/2007/ During SFY 2005, the toll-free Idaho CareLine averaged 331 calls per month from persons seeking a Medicaid dentist, down 27 percent from 2005. Calls totaled 3,969 seeking a Medicaid dentist and 741 persons seeking free or reduced dental services. A total of 567 dentists (64%) of 884 dentists with an Idaho license and in-state address had one or more paid Medicaid claims and 325 (57%) of Medicaid billing providers had paid claims of $10,000 or more. Five Idaho counties are without a dentist and 11 counties have no Medicaid billing dentist who saw 50 more beneficiaries under age 21.//2007//

/2006/ During SFY 2004, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist, up 86 percent from 2003. Calls totaled 5,459 seeking a Medicaid dentist and 602 persons seeking free or reduced dental services.//2006//

/2005/ During state fiscal year 2003, the toll-free Idaho CareLine averaged 244 calls per month from persons seeking a Medicaid dentist. From July 2002 through June 2003, the Idaho CareLine received 2930 calls for a Medicaid dentist and another 431 calls from persons seeking free or reduced fee dental services. In April 2002, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 75 dentists responded that they were.//2005//

/2004/ During state fiscal year 2002, the toll-free Idaho CareLine averaged 455 calls per month from persons seeking a Medicaid dentist. From July 2001 through June 2002, the CareLine received 5,455 calls for a Medicaid dentist and another 293 calls from persons seeking free or reduced fee dental services. In April 2001, Idaho CareLine staff called each dentist with an active license to determine if they were accepting new Medicaid patients; only 90 dentists responded that they were.

During federal fiscal year 2001, 122,526 children were enrolled in the combined Medicaid/ Children's Health Insurance Program (CHIP) and 29 percent had a dental visit or service. In FFY 2002, the number enrolled increased to 133,479, but the number of children who received any dental services decreased to 19 percent. According to the 2003 Idaho Kids Count Book, 28 percent of Idaho children under age 18 are without health insurance coverage, up from 18 percent in 1994, and an estimated 29,600 Idaho children under age 19 years are eligible but not yet enrolled in CHIP.

/2006/ During SFY 2004, the average monthly enrollment of eligible children in Title XIX Medicaid was 100,520 and 11,235 in Title XXI CHIP.//2006//

/2005/ The number of children insured through Medicaid and CHIP grew 154 percent between 2000 and 2003. In 2003, 33% of eligible children age 21 or younger and 21% of children age 1-5 years received a dental visit or service, an increase of 14% and 11% respectively over 2002.//2005//

As of June 2002, there were 767 active licensed dentists statewide, with 552 (72%) enrolled as Medicaid providers. Fifty percent were significant providers, receiving $10,000 or more in annual Medicaid payments. During state fiscal year 2002, the toll-free Idaho CareLine averaged 479 calls per month from persons seeking a Medicaid dentist or free/reduced fee dental services. From July 2002 through March 2003, the number of calls to the CareLine dropped to an average of 268 per month, reflecting public awareness that adult Medicaid dental benefits had been reduced to emergency care only. CareLine staff periodically calls each Idaho dentist with an active license to determine if they are accepting new Medicaid patients. As of March 2003, 11 of 44 counties had no dentists accepting new Medicaid patients and 7 counties had no dentists who accept Medicaid.

/2005/During 2003, there were 772 dentists and 769 dental hygienists with an Idaho license and in-state address. Ninety-one percent (705) of dentists were enrolled as Medicaid/CHIP providers, but only 59% (413) had one or more paid Medicaid claims in 2003. Dentists with paid Medicaid claims > $10,000 numbered 182 (26%); 11 of 44 counties had no dentists in this category. Currently, 30 of Idaho's 44 counties are designated as either a geographic or population group Dental Health Professional Shortage Area.
//2005//

/2006/ As of July 2004, there were 807 active licensed dentists with Idaho addresses; 563 (69.8%) dentists had at least one paid Medicaid claim and 319 (39.5%) had paid claims > $10,000, a substantial increase over 2003. Four of the 44 counties had no enrolled Medicaid dentist. //2006//

/2009/ With Medicaid reform and an emphasis on preventive health, Medicaid recipients now receive preventive dental visits through the Idaho Smiles dental plan. //2009//

Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho.

We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services. We continue to pursue an enhancement of Medicaid for family planning services, which will reduce unintended pregnancy and improve the well being of children and families. Additionally, we have submitted a proposal within the Department of Health and Welfare to use TANF/TAFI funds to provide family planning services to reduce out-of-wedlock births. No decision has been made to date. We have collaborated with Medicaid to review the payment reimbursement schedules currently used for clinic activities for Medicaid eligible children in our Children's Special Health Program (CSHP). We have facilitated discussions between Medicaid and the District Health Departments to improve referral to and the use of CSHP coordinators and district health staff in Medicaid-funded care coordination. These meetings resulted in clarifying policies, identifying staff relationships between the two units, and each access unit developing/implementing a written protocol for the process.

/2005/ We are no longer pursuing TANF funds for family planning activities. We are working to expand options under Medicaid to allow coverage for family planning services for two years postpartum for women to improve preconception health and assure adequate spacing of births.//2005//

The Idaho Children's Health Insurance Program, CHIP, was implemented in October 1997 as a Medicaid expansion to take advantage of federal matching funds targeted to making health insurance available for uninsured children in families with limited incomes. Federal funds were available in October 1997, and former Governor Batt directed the Department to have the program immediately in place to provide increased access to care for children in Idaho. The first year the program operated at 160% of Federal Poverty Level (FPL) until July 1998, when it was reduced to 150% FPL based on legislative action. A citizen's task force was appointed to study and make recommendations on the long-term design for the program. Their report was delivered to the Department in November 1998 for review and submission to the new Governor and Legislature.

In March of 1999, the new director of the Department of Health and Welfare formed a CHIP steering committee to revisit the citizen's task force recommendations and recommendations regarding implementation. At the same time, a CHIP executive oversight committee was formed to oversee the project and make the final decisions. The Health Policy Supervisor, Health Resources Section, formerly of the Bureau of Health Policy and Vital Statistics, served as a liaison between the Division of Health and the steering committee. The steering committee submitted their final report with 21 recommendations to the oversight committee in September 1999. The oversight committee made several decisions based upon these recommendations. Many of these decisions surrounded the issue of simplifying the enrollment process. This simplification process resulted in reduction of the application form from a 17 page document to a 4 page document, and was implemented in November 1999. In addition, the oversight committee decided to leave the program as a Medicaid expansion for the present, but will re-evaluate the possibility of doing a voucher system if there are major changes in the program. The remaining recommendations are being evaluated for implementation impacts.

/2009/ Medicaid has developed a 2 page child only application form to simplify the enrollment process. This form is being piloted in the Children with Special Health Care Needs clinics. //2009//

At the writing of the 2001 MCH Block Grant application, the importance of outreach to CHIP enrollment had been recognized and was made a top priority in the regional offices as well as the central office. The Department of Health and Welfare's aggressive campaign to identify children eligible for CHIP resulted in identifying four times as many who qualify for Medicaid. After starting out slowly with just a few hundred children in 1997, CHIP participation skyrocketed over the next two years to more than 10,000 children. At the same time, the promotional effort had been credited with uncovering tens of thousands of new Medicaid participants. However, in an effort to

curb the growth of the Medicaid budget, the State Legislature voted to cap the CHIP program as well as limit recruitment.

Analysts say the state would meet the federal promotional requirement by simply issuing a brochure. Ultimately, the legislature extended restrictions on promoting program participation to all state health and social service programs. How this mandate will impact program services remains to be seen.

Idaho's current Governor has declared this the "Generation of the Child", and in doing so, has established a goal to make children our number one priority. High on his list of children's issues has been the low immunization rates among our 0 - 24-month-old population. In an effort to impact these low rates, the Governor, working with the 1999 State Legislature, helped frame a law which when enacted, established a statewide immunization registry. Later that year, the state entered into an agreement with Scientific Technologies Corporation to develop a plan for the implementation of the immunization registry, the immunization reminder information system (IRIS). The registry is now operational and has been for over two years. The Immunization Program, within the Bureau of Clinical and Preventive Services, plays a key role in this process while continuing to provide funding for other strategies designed to impact the low rates.

/2004/ The number of providers providing vaccination data to IRIS increased to 129. To date there are over 195,000 patient records and over 2,000,000 vaccination records. All but 43,667 of the vaccination records are for individuals 18 and younger.

/2005/ As of 6/10/04: 203 Health Care Providers, 554 Schools and Daycares are enrolled 220,316 patient records and 2,527,407 vaccinations. 162,514 records are 18 and younger, 57,802 are over 18.//2005//

/2006/ As of 6/10/05: 253 Health Care Providers, 758 Schools and Daycares are enrolled in IRIS. 265,228 patients total, 3,124,787 vaccinations. 190,712 records are 18 and younger, 74,516 are over 18.//2006//

/2007/ As of 05/29/06: 276 Health Care Providers, 903 Schools and Daycares are enrolled in IRIS in Idaho and 7 providers from border areas in Washington State are also enrolled. 297,554 patients total, 3,739,209 vaccinations. 290,734 records are 18 and younger, 85,422 are over 18. 93% of all Idaho newborns are consented into the Idaho Immunization Registry. Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2007//

/2008/ As of 05/25/07: 298 Health Care Providers, 1,019 Schools and Daycares are enrolled in IRIS in Idaho and 8 providers from border areas in Washington State are also enrolled. 335,911 patients total, 4,290,900 vaccinations. 237,834 records are 18 and younger, 98,077 are over 18. 94% of all Idaho newborns are consented into the Idaho Immunization Registry. We track this differently now so I don't know what you want to include-we know for 2006 that 87% of newborns submitted to vital stats are also consented for IRIS. According to the daily status in IRIS, we currently have 20,231 children under the age of 1 year in IRIS so additional children are being added after being in the hospital. Are we still using 20,000 for the birth cohort or 21,000? Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2006 - 2007.//2008//

/2009/ As of 05/23/08: 298 Health Care Providers, 798 Schools and Daycares are enrolled in IRIS in Idaho and 8 providers from border areas in Washington State are also enrolled. 373,236 patients total, 4,927,664 vaccinations. 264,747 records are 18 and younger, 108,489 are over 18. 94% of all Idaho newborns are consented into the Idaho Immunization Registry. According to the daily status in IRIS, we currently have 20,863 children under

the age of 1 year in IRIS so additional children are being added after being in the hospital. Routine monitoring of the data quality in the IRIS system is a high priority of the program and plans are being developed to implement a new data quality assessment component during 2008-2009.//2009//

Another recent initiative within the state is an effort to better coordinate health services to clients. This is exemplified by the vision statement of the Idaho Department of Health and Welfare's new "Strategic Plan 2001 - 2004" which is to Provide leadership for development and implementation of a sustainable, integrated health and human services system. While the plan is obviously intended for the entire population of Idahoans, its vision, goals and objectives describe an approach consistent with the MCH needs assessment/performance measure model used in the current block grant. Every four years, the Department will collect and compile health and safety data, prioritize health and safety issues based on this data, and develop strategies, set expected outcomes measures and identify resources. Following that process, there will be an evaluation of the impact of strategies on improving the status of health and safety priorities. Other features of the plan call for identification of family and community resources necessary to support the wellbeing of Idahoans and identification and application of models of cooperative relationships to support an integrated and sustainable health and human services system.

/2009/ The 2007 -2011 Department Strategic Plan is comprised of three goals: 1) Improve the health status of Idahoans; 2) Increase the safety and self-sufficiency of individuals and families; and 3) Enhance the delivery of health and human services. A separate, but integrated Department Customer Service Plan was put forth in October 2007. The customer service standards -- the 4 c's -- are caring, competence, communication, and convenience. //2009//

/2004/ The Department is currently in the process of designing an Any Door initiative to ensure clients are linked with needed services. This will include all services offered by the Department of Health and Welfare and the public health districts as well as a referral system for services outside the scope of these agencies. The vision is to have a single enrollment form and navigator type position to help clients access services for which they are in need and for which they qualify. This is a large expansion from the MCH activities implemented within the past few years such as the immunization -- WIC linkage. As this model develops, a focus will be placed on a client-centered plan with specific goals including exit from public assistance. The target date to pilot the project is January 1, 2004.

/2005/ The Any Door Initiative has been piloted in one small office in health district 2 and is now being implemented district-wide. While the focus of this service integration project has been on the social services delivered through regional offices of the Department of Health and Welfare, coordination of service application and referral is occurring between the Department and the health districts. This will include common enrollment forms that will overlap to district delivered services such as WIC and CSHP and a navigation function that will assist clients in accessing public health services even though they are applying through a social service center.//2005//

/2005/ Idaho will be funding an obesity project this coming year with MCH funds from last year's grant. Not all funds were spent as planned because one time state funding was available to cover some of the MCH expenses. These funds will be administered by the WIC program and contracted to the district health departments. The health departments will provide training to physicians who care for children. The training will include: using body mass index (BMI) to identify children at risk for becoming overweight; importance of encouraging families to have meals together and engage in exercise (Bright Futures Materials); and to promote and support continuation of breastfeeding. An evaluation will be conducted by staff from the Immunization Program Quality Assurance Review Team to determine the use of BMI in physician offices. A follow-up will also be conducted among parents that volunteer to participate in the project to determine if they have changed their meal time habits and increased exercise.

Another project that is included in the FFY 05' budget proposal is a perinatal project. Currently, there is considerable anecdotal evidence indicating poor birth outcomes among births attended by non-certified midwives. This project will be two fold: first to gather data on birth outcomes of deliveries attended by lay midwives and to begin education efforts to ensure expecting parents are aware of the benefits of working with qualified individuals to improve the opportunity to have healthy babies.

And the last new initiative is to fund a full-time research analyst located within the Division of Health's Bureau of Vital Statistics and Health Policy to work with MCH programs. The focus will be on developing and analyzing outcome measures for each of the MCH funded programs.//2005//

/2006/ Idaho is initiating a project to improve access to prenatal dental care, targeting low income women during their second trimester. This project will seek to achieve two goals, first is to increase referrals by obstetric providers, second to increase the number of pregnant women that actually receive dental services during pregnancy//2006//

/2008/ During state fiscal year 2007, the breastfeeding coordinator in the WIC program completed a breastfeeding friendly workplace initiative. WIC staff worked with regional breastfeeding coalitions on effective means of working with employers to make simple changes that encourage continued breastfeeding. The coalitions were provided toolkits that they can then provide to employers. //2008//

Finally, as SFY 2001 drew to a close, the continuation of genetic laboratory and clinical services in Idaho by the Bureau of Laboratories, became problematic. With the retirement of the Genetics Program Coordinator and the loss of a trained cytotechnologist, we were faced with the problem of recruitment of experienced individuals. At the same time we encountered budget problems with the operation of the Bureau of Laboratories.

In the face of these circumstances, we attempted to evaluate the status and future of the Genetics Program. To assist us, we consulted on several occasions with one of our Board Certified Geneticist consultants and his associates. This came on the heels of indications that one or both of our local regional medical centers had an interest in establishing both genetic clinical and/or laboratory capability. Due to a lack of medical geneticists in the state, we explored the prospect of recruiting and sharing a trained individual with one or both hospitals. After those discussions, it became clear that any such opportunity was not likely to take place in the near future. As a result, a decision was made to reorganize the Genetics Program, leaving the laboratory activities in place at the Bureau of Laboratories and transferring the newborn screening and the genetics clinic activities to the Bureau of Clinical and Preventive Services, the Title V agency.

/2004/ The previous program manager for the Genetics and Newborn Screening Programs resigned this past spring. At that same time the Department has been requested to cut 117 positions. The Program Manager position remains vacant and we are uncertain at this time when we will be able to fill it. Anne Spencer, a Masters level genetics counselor, continues to serve as a point of triage for clinical services, providing specialty consultation to health care staff, compiling family history, reviewing medical records, assessing risk and providing counseling to individuals and families.

/2005/ Brett Harrell, Manager of the state CSHCN Program, is now responsible for managing genetics and newborn screening. This was a natural fit since many of the children served through the genetics program and those diagnosed through newborn screening fall within the federal definition of CSHCN.//2005//

/2007/ In 2007 Mitch Scoggins replaced Brett Harrell following Brett's Retirement. Mr. Scoggins now manages the CSHCN, Newborn Screening and Genetics Programs. //2007//

/2009/ In 2008 the CSHCN hired Carol Christiansen, RN to support the Newborn Screening and CSHCN Programs. //2009//

/2004/ Another significant change in the area of genetics coming in September 2003 will be a new pediatric endocrinologist at St. Luke's Hospital in Boise Idaho. This will greatly reduce the current backlog of patients seen at the Department's genetics clinics and provide opportunities for the program to focus on education activities. And lastly, as a result of a General Fund reduction, the state Newborn Screening Program was required to change their rules. The new rules, which were approved by the 2003 legislature, include a fee for service structure and mandates screening for 5 metabolic conditions. Idaho currently tests for over 24 conditions via tandem mass spectrometry at the state contract lab, Oregon Public Health Laboratory.

/2005/ Dr. Alex Karmazin, Pediatric Endocrinologist, is on staff with St. Luke's Regional Medical Center as planned and all endocrinology patients previously served by state staff will be transitioned to Dr. Karmazin by October 1, 2004. All new patients are referred direct.

The Newborn Screening Program recently expanded newborn screening testing to include hemoglobin disorders and Congenital Adrenal Hyperplasia.//2005//

/2009/ The Newborn Screening Program has expanded to include Cystic Fibrosis testing.//2009//

Current MCH Priorities

A reexamination of health priority areas was conducted in May 2001, using an abbreviated needs assessment process. Division of Health and District Health Department representatives reviewed health status data and current program expenditures. Program staff provided summaries and proposals for continued and new activities.

Issues were prioritized based upon these criteria: (1) magnitude of the problem, high incidence or prevalence; (2) seriousness of the consequences of the problem; and (3) feasibility of positively impacting the indicator, amenable to intervention/intervention proven effective by research. This process reaffirmed Idaho's areas of need identified in the five-year needs assessment and focused MCH activities during FY 2002 to impact these issues. The ten areas identified are:

Infant mortality and low birth weight
Adolescent pregnancy
Vaccine preventable diseases
Injuries
Substance and physical abuse
Investigation and control of "clusters" of reportable diseases and conditions
Prenatal care utilization
Children's access to health care coverage
Risky behavior in adolescents
Increased data capacity

/2009/ A number of factors have greatly influenced Idaho's MCH Title V program and the state priorities that were identified in the 2006 application. Below is a list of state priority areas that currently reflect the need of Idaho's MCH population. These are not in priority order; they are presented as a list of 7 key areas needing attention.

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.
2. Public Health will work with Medicaid to explore options to maximize services to the MCH population.

3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.
4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2 years of age.
5. Work with Medicaid, the newly formed Division of Behavioral Health and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.
6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.
7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy. //2009//

An attachment is included in this section.

B. Agency Capacity

The State Title V agency in Idaho remains within the Division of Health of the Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), epidemiology services, STD/AIDS (including prevention and Ryan White CARE Act, Title II), immunization, WIC, programs for children with special health care needs, the SSDI position and grant, and most recently the newborn metabolic screening program and genetics clinics. The chief of BOCAPS provides additional fiscal oversight and program review for injury prevention, oral health, adolescent abstinence education grant, perinatal data analysis, and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Health, Bureau of Clinical and Preventive Services, Bureau of Health Promotion, Bureau of Health Policy and Vital Statistics and Division of Family and Community Services are included with this submission (Figures 4, 5, 6, 7, 8 and 9). /2006/ Bureau of Health Promotion is now the Bureau of Community and Environmental Health. //2006//

/2005/ Two new programs were added to the Bureau of Clinical and Preventive Services; Worker Health and Safety and Women's Health Check. Worker Health and Safety is a program focused on reducing injuries to Department of Health and Welfare employees and does some consultation to the general public. Women's Health Check is the Idaho Breast and Cervical Cancer Screening Program. Also, the Bureau of Health Promotion is now called the Bureau of Community and Environmental Health.//2005//

/2006/ A new program was added to the Bureau of Clinical and Preventive Services to support the Division of Health's information technology programs including WIC's data base, the Immunization Registry, Health Alert Network, and the National Electronic Disease Surveillance System. This program's primary function is a help desk and to also assist with managing system upgrades and maintenance. //2006//

/2007/ With the resignation of the Health Systems Support program manager in February 2006, and the retirement of one of the employees in April, the management of the IT help desk staff was placed back in the programs, WIC, Immunizations and Office of Epidemiology and Food Protection. //2007//

/2003/ Responsibilities for the Child Mortality Team have been transferred to the Bureau of Emergency Medical Services during state fiscal year 2002.

/2007/ The Child Mortality Review Team was disbanded in 2003. Idaho is aggressively overhauling the EMS patient care reporting system and implementing a trauma registry for hospitals to report on severely injured patients to counter pose against mortality data. The

published reports of the CMRT showed that injury was the prevailing issue. //2007//

/2004/ As of January 2003 epidemiology services are now provided through the Office of Epidemiology and SSDI operates out of the Bureau of Health Policy and Vital Statistics.

/2004/ In an effort to coordinate MCH programs divided among the various offices, bureaus and divisions, quarterly meetings are held among all MCH funded programs as well as others such as WIC and substance abuse who are directly involved with providing services to the MCH population. Each meeting has a set agenda established by the MCH director with input from meeting participants. Based on comments provided during last year's review, the meeting functions have changed. They still include information sharing, but added to each meeting are planning discussions. For example, during our most recent meeting, a discussion was facilitated by the Asthma program manager to determine how multiple MCH programs can work together to most efficiently serve our clients. Another phase of the discussion included planning for addressing obesity among the MCH population. Input was gathered from the meeting participants and an action plan will be developed among the specific programs targeted to initiate this collaborative effort.

/2007/ Due to waning attendance, the quarterly MCH meetings were disbanded in 2005. We are trying a new approach of monthly meetings with the Bureau Chiefs of Clinical and Preventive Services, Community and Environmental Health and a representative from the Division of Medicaid. This planning should identify and support opportunities for program integration and enhancement. Others will be brought to the table as is appropriate. //2007//

/2008/ The Medicaid representative with whom we were regularly meeting resigned and the position was not refilled. There is not currently an individual at Medicaid who functions in a broad capacity and is capable of addressing a wide range of issues. The Bureau Chiefs of Clinical and Preventive Services (MCH Director) and Community and Environmental Health meet regularly and contact personnel from other Divisions as necessary. //2008//

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." He/she serves on the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2010 (HP) objectives for the nation.

Bureau of Clinical and Preventive Services (BOCAPS)

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. That portion of the Bureau's mission, related to maternal and child health, fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

Newborn Screening Program

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." The current newborn test battery includes screening for congenital hypothyroidism, galactosemia, maple syrup urine disease (MSUD), and biotinidase deficiency, in addition to PKU.

/2003/ The 2002 Legislature discontinued state fiscal support for the Idaho Newborn Screening Program with the start of state fiscal year 2003. With support from community organizations, such as the Idaho Medical Association, the Idaho Hospital Association, the Idaho Perinatal Project, and

the Idaho Chapter of the American Academy of Pediatrics, Division of Health leadership instituted a fee for the Newborn Screening Program, effective July 1, 2002.

/2004/ This new fee structure was approved by the 2003 State Legislature. The impact of this new structure has been to increase the number of conditions diagnosed through the program. Since Oregon Public Health Lab has been providing screening services and physician consultation for decades, this change was transparent at the provider level other than the new fee structure. We continue to see a high rate of testing among our infant population with less than two percent not being tested, opting out for religious or personal reasons.

/2005/ Two new tests were added to the newborn screening program this past year. They include hemoglobinopathies and Congenital Adrenal Hyperplasia.//2005//

/2007/ Cystic fibrosis will be added to the newborn screening program in the fall of 2006. //2007//

/2009/ CF was added to newborn screening testing in July of 2007. //2009//

Children's Special Health Program.

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn.

/2005/ The CSHP program manager is now administratively responsible for overseeing the state newborn screening and genetics programs.//2005//

/2006/ CSHP rules were revised during the 2005 legislative session. The most significant change was to change eligibility criteria. Previously the program was open to children meeting certain diagnostic criteria regardless of insurance status. The rules have been revised to limit program services to uninsured children only. //2006//

The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

/2003/ Roger Perotto retired as of August 2001. Russell Duke, M.S., became the Chief of the Bureau of Clinical and Preventive Services in June of 2002. He was Acting Chief of the Bureau of Clinical and Preventive Services from December 2001 through his permanent appointment. His prior position was Chief, Bureau of Environmental Health and Safety.

/2007/ Russell Duke, M.S., resigned as Bureau Chief of the Bureau of Clinical and Preventive Services in October 2006. In December 2006, Ms. Dieuwke A. Spencer, R.N., M.H.S. was hired as Bureau Chief. Prior to this position, Ms. Spencer was the Section Manager for Chronic Disease in the Bureau of Community and Environmental Health for a year and previously the Supervisor for the Office of Epidemiology and Surveillance at Central District Health Department in Boise, Idaho where she had been employed for 14 years. //2007//

Susan E. Ault, B.S.N., R.N., A.R.N.P., has been the Family Planning Program Manager since 1988. This program has been re-named the Reproductive Health Program. Ms. Ault has also served as a provider of family planning services, school nurse and public health nurse for thirteen years prior to her appointment within the Bureau.

/2006/ Susan Ault has resigned her position and will be working with the Idaho Primary care Association. Her position is presently open for new applicants.//2006//

/2007/ Anne Williamson retired in December 2005 as the STD/HIV Program Manager. Jesus Sandoval, M.S.W. was hired in April 2006 as the Reproductive Health Program Manager. Mr. Sandoval has administrative oversight of the Title X program as well as the STD/AIDS program. //2007//

/2008/ Mr. Sandoval left the Department in October of 2006. In January 2007 Ms. Kathy Cohen, MS, was hired as the program manager for the Sexual and Reproductive Health Program. She has administrative oversight of the Title X program as well as the STD/AIDS program. //2008//

Christine Hahn, M.D., has been the State Epidemiologist since February 1997. Dr. Hahn is funded 0.5 FTE through the MCH Block Grant. She provides epidemiological support and consultation to all Title V programs and currently provides staff leadership to the Child Mortality Review Team.

/2004/ Dr. Hahn continues to provide consultation to all Title V programs in combination with the Deputy State Epidemiologist, Leslie Tengelsen. While support levels remain the same, funding is actually going to .3 of Dr. Tengelsen's salary and no support of Dr. Hahn's salary.

Leslie Tengelsen, Ph.D., D.V.M., has been the Assistant State Epidemiologist since 1998. She also provides epidemiological support and is currently involved in providing data analysis for the Bureau of EMS in assessing emergency response capability for pediatric patients as part of an MCH EMSC grant.

/2007/ Dr. Tengelsen's support levels remain the same, funding is at 0.5 of her salary. //2007//

/2003/ Drs. Hahn and Tengelsen are in the newly created Office of Epidemiology and are not a part of the Bureau of Clinical and Preventive Services.

/2005/ Jared Bartschi, Health Program Specialist in the Office of Epidemiology and Food Protection, is responsible for HIV/AIDS and STD surveillance and epidemiology, and other projects as assigned.//2005//

/2007/ Mr. Bartschi is funded at 0.25 FTE through the MCH block grant. //2007//

/2007/ Meredith Duran, Technical Records Specialist with the Office of Epidemiology and Food Protection, is funded 0.25 FTE through the MCH block grant. Ms. Duran provides support for the e-HARS computer system. //2007//

/2008/ Meredith Duran has moved to a Technical Records Specialist position with the Sexual and Reproductive Health Program. The position in the Office of Epidemiology and Food Protection is currently vacant and being recruited. //2008//

/2005/ Brett Harrell, B.S.W., M.A.T., was appointed Manager, Children's Special Health Program, in May 1995, after serving as the Director of Special Projects since November 1994. He was also given managerial responsibility for the newborn screening and genetics programs in the fall of 2004. Mr. Harrell has more than twenty years of experience in administration and management, which has included directing a regional hospice organization and a statewide diabetes association.//2005//

/2008/ Brett Harrell retired in December 2006. Mr. Mitch Scoggins, MPH assumed the position of CSHP Manager on May 7, 2007. Mitch has extensive international health experience where he has gained valuable experience in systems change and development. Judy Watson, RN who worked 10 hours per week with the newborn screening program also retired in December 2006. This part-time position has not been refilled. //2008//

/2009/ On the 21st of April 2008 Carol Christiansen joined CSHP in the role of Nurse, Registered Senior. Ms. Christiansen comes to Idaho with 14 years of experience in Florida's Children's Medical Services program, and is well qualified to bring clinical and programmatic expertise to CSHP. //2009//

Judy Peterson, M.S., R.D., L.D., provides nutrition consultation to the Children's Special Health Program for PKU clients as well as other nutrition related issues. She also works with the Idaho WIC Program.

/2004/ Judy Peterson, resigned in July of 2002, but continues to provide nutrition consultation to CSHP for PKU clients through her part time employment with St. Luke's Regional Medical center, a contractor of CSHP. Her position in WIC was refilled, but has not yet been used for PKU consultation. This may take place during the course of the coming year.

Emily Geary, M.S., R.D., L.D., has worked as the Nutrition Education Coordinator for the Idaho WIC Program since 1998. Ms. Geary serves as a consultant for metabolic conditions impacted by nutrition, for obesity initiatives, and began providing consultation to CSHP in 2004 for children with PKU and other metabolic conditions.

/2006/ Emily Geary transferred from the WIC program to the Breast and Cervical Cancer Screening Program. Jean Heinz was hired in her place. Ms. Heinz has over 20 years of experience as a Registered Dietitian and most recently worked for the Idaho State Department of Education, Child Nutrition Programs.//2006//

/2007/ In January, 2005, Katie Bagley, RD, LD, was hired in a part-time position to provide dietary and nutritional information to Idaho PKU patients and families. Katie's first several months in the position resulted in quantifiable increases in formula usage by patients, greater patient compliance with monthly phe level blood tests, and positive feedback from families concerning her involvement with and commitment to the health and wellbeing of their children. //2007//

Linda Morton, M.P.H., R.D., L.D., I.B.C.L.C., has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 1993. Ms. Morton has over 20 years of varied work experiences in public health and is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.

/2005/ Linda Morton is working with the Department's Any Door Initiative and Cristi Litzsinger, R.D., L.D., I.B.C.L.C., is serving as the State Breastfeeding Promotion and Outreach Coordinator for the WIC Program. Cristi has 7 years of experience working as a WIC Nutritionist.//2005//

/2008/ Cristi Litzsinger is an International Board Certified Lactation Consultant and Registered/Licensed Dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho.//2008//

/2006/ Linda Morton has resigned from the Department of Health and Welfare. Cristi Litzsinger was hired in her place. Ms. Litzsinger has 8 years experience working in WIC and is an Internationally Board Certified Lactation Specialist.//2006//

Christina Giso, M.B.A., is Idaho's current MCH State Systems Manager (formerly designated the State Systems Development Initiative Coordinator) and the new Genetic Services Program Coordinator. Her advanced degree is in health systems administration, and her primary focus has been the MCH block grant needs assessment and performance and outcome measures. Currently, she serves as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP).

/2003/ Christina Giso is responsible for the Idaho Newborn Screening Program and the Genetic

Services Program. She is no longer the AMCHP State Data Contact.

/2004/ Christina Giso resigned in April of 2003. The position is currently vacant and may not be filled pending Full Time Employee (FTE) reductions in the department. If the position is eliminated, the responsibilities will be transitioned to CSHP.

/2008/ The Immunization Program Manager resigned in February 2007. Ms. Rebecca Coyle, MS, assumed the position and started in April. Ms. Coyle most recently served as a CDC Public Health Advisor to the Minnesota Immunization Program. //2008//

/2008/ In March 2007 Traci Berreth, MCH Special Projects Coordinator accepted a Division level position. The Special Projects Coordinator was a 0.5 FTE temporary position that has not been refilled at this time. //2008//

Bureau of Health Promotion

/2005/ Name changed to the Bureau of Community and Environmental Health.//2005//

Ginger Franks, Dr.P.H., has been the Injury Prevention Program Manager since 1996. She was a public health microbiologist in the California system before coming to Idaho. Her program is focusing on motor vehicle safety and sexual assault prevention, collaborating with the Departments of Transportation and Law Enforcement.

/2005/ With the strengthening of Idaho's adult safety restraint law in July 2003, the program objective addressing adult safety restraints was dropped. In 2005 we will be working to move the child safety restraint program to state and local partners. State partners will include Idaho Transportation Department and AAA-Idaho.//2005//

/2003/ Ginger Floerchinger-Franks, Dr.P.H. Her program is focusing on motor vehicle safety, bicycle safety, pedestrian safety, and teen rape prevention, collaborating with the Department of Transportation. Additionally, Dr. Franks is the coordinator for the Preventive Health & Health Services Block Grant and the Principal Investigator for the Rape Prevention Education Grant.

/2005/ The (Unintentional) Injury Prevention Program is changing focus by beginning to work with the elderly population. Current objectives focus on developing a network of exercise classes working on prevention falls and transitioning the child car safety seat program to other partners.

Kaili McCray has taken the lead for the Sexual Violence Prevention Program and is acting as Unit Manager for the Injury and Violence Prevention Unit. Although Ginger remains Idaho's coordinator for the Preventive Health and Health Services Block Grant, Kaili is the Principal Investigator for the Rape Prevention Education Grant.//2005//

/2004/ Injury Prevention Program's role has enlarged to include elderly fall prevention and suicide prevention. Kaili McCray, Ph.D., has been hired as the Manager for the Rape Prevention Education Program and is the Principal Investigator for the Rape Prevention Education Grant.//2004//

/2003/ Shelli Rambo-Roberson has replaced Angela Wickham as the Adolescent Pregnancy Program Manager. Shelli has a BS in Social Work and a BA in Education and has been the Adolescent Pregnancy Prevention Manager since last September. Her program is abstinence based and she works in collaboration with the seven health districts to offer community and school programs; the Idaho Governor's Council on Adolescent Pregnancy Prevention to provide a statewide media campaign; and other community programs to offer mini-grants that support youth asset building and pregnancy prevention at the local level.//

/2009/ Mercedes Munoz replaced Shelli Rambo-Roberson as the Adolescent Pregnancy

Prevention Program Manager. The program has moved from the Governor's Office to the Bureau of Community and Environmental Health. //2009//

/2006/The Adolescent Pregnancy Program has been transferred to the Governor's Office.//2006//

Lisa Penny, B.S., R.D.H., has been Oral Health Program Coordinator since 1987. Ms. Penny has served within the Bureau since 1970, conducting school and migrant programs throughout the districts for seven years, and later directing educational and training activities as the state Dental Health Education Consultant. Ms. Penny has established a statewide program to promote oral health, increase use of preventive dental health measures, and improve access to dental care.

/2008/ Lisa Penny retired in March 2007 after 37 years with the Oral Health Program. Interviews for the Oral Health Program Manager position were conducted in May 2007. //2008//

/2009/ Debra James, R.D.H. was hired as the Oral Health Program Manager in 2007. She has since resigned, and efforts are underway to refill the position which is vacant at this time. //2009//

/2008/ The Adolescent Pregnancy Program will be transferred from the Governor's Office back to the Bureau of Community and Environmental Health in July 2007. //2008

Office of Rural Health and Primary Care

Andrea Fletcher, M.P.H, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.

/2005/ Mary Sheridan, RN, is the Director of the State Office of Rural Health and Primary Care. As the Director, she coordinates state programs to improve health care delivery systems for rural areas of the state.//2005//

Laura Rowen, M.P.H., is the Primary Care Office Manager. Her role is to assess the state for areas of medical under service, barriers in access to health care, and identification of health disparities.

/2009/ In November 2007, the Division of Health created a new bureau by uniting the Health Preparedness Program and the Office of Rural Health and Primary Care into the Bureau of Health Planning and Resource Development. Both programs are health systems focused, working closely with hospitals, federally qualified health centers, emergency medical service providers, local district health departments, associations, universities and other key players in the health system. By joining forces into this new bureau, it better integrates complementary activities, avoids program duplication and helps share vital resources, increasing the Division of Health's overall capacity for planning and supporting sustainability of health systems. Angela Wickham, M.P.A., a nine year employee of the Department of Health and Welfare, is the bureau chief.

Bureau of Health Policy and Vital Statistics

/2008/ The Bureau Chief, Jane S. Smith, was appointed Division of Health Administrator in January 2007. James Aydelotte assumed the position of Chief, Bureau of Health Policy and Vital Statistics in February 2007. Mr. Aydelotte has been with the Bureau for ten years. //2008//

Dianna Willis, M.A., has been the Perinatal Research Analyst (a.k.a. Senior Research Analyst) since 1998. She is responsible for computing and analyzing health statistics

regarding prenatal care, maternal risk factors, and birth outcomes. She was instrumental in conducting the Pregnancy Risk Assessment Tracking System (PRATS), and will be involved in conducting future surveys. Additionally, she has analyzed women's access to and utilization of prenatal care in Idaho, using Geographic Information Systems (GIS) technology. She has served as the State Data Contact to the Association of Maternal and Child Health Programs (AMCHP) and will soon be the MCH State Systems Manager.

/2003/ Dianna Willis is the current SSDI Program Manager for Idaho.

/2004/ Dianna Willis also serves as the State Data contract for the Association of Maternal and Child Health Program (AMCHP) and on the Advisory Board for the Idaho Perinatal Project.

/2006/ Dianna Willis recently resigned and the position is currently open for new applicants. //2006//

/2007/ Teneale Chapton, M.S., has been the Perinatal Research Analyst (a.k.a. Principal Research Analyst) since July 2005. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Teneale Chapton is the current SSDI Program Manager for Idaho as well as a member of the Association of Maternal and Child Health Programs (AMCHP) and serves on the Advisory Board for the Idaho Perinatal Project. //2007//

/2009/ Teneale Chapton, M.S. accepted the position of coordinator for the immunization registry (IRIS). Jacqueline Daniel is now the research analyst responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Jacqueline is the current SSDI Program Manager for Idaho and serves on the Advisory Board for the Idaho Perinatal Project. //2007//

/2004/ Cory Reed is a Senior Research Analyst with a background in statistics and statistical computing that is working with MCH programs. Cory works with a variety of data sources to provide analytical support for MCH related activities including WIC, family planning services, and infertility prevention. Cory also has several years' experience using public health survey data including the Behavioral Risk Factor Surveillance System to analyze risk factors, chronic disease prevalence, and access to care issues that affect women's health.

/2005/ Cory Reed resigned and Greg Seganos has been hired in his place. Mr. Reed worked half time for MCH. Mr. Seganos works full time for MCH. //2005//

/2008/ Mr. Greg Seganos resigned in October 2007. In February 2007 Mr. Ward Ballard assumed the position of MCH research analyst. This continues to be a full time position. //2008//

Division of Family and Community Services

Patricia Williams, is the Idaho CareLine Community Resource Coordinator for our toll-free referral service.

/2007/ Patricia Williams is the Idaho CareLine Program Supervisor. //2007//

/2009/ Patricia Williams retired. Nina Dillon is the Idaho CareLine Supervisor. //2009//

District health departments, who carry out implementation of state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, dental hygiene, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the master's level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, selected materials/supplies and funding for special projects. The main funding streams that complement Title V are county funds, fees, the State General Fund, Title X, Preventive Health and Health Services Block Grant, CDC's Immunization, HIV/AIDS Programs and the WIC Program.

C. Organizational Structure

Statewide service delivery for the state agency is carried out by the public health districts and other non-profit and community based organizations through written contracts between the state and the agencies and organizations. The contracts are written with time-framed and measurable objectives, and are monitored with required progress reports. Site visits are also made to programs as part of monitoring both performance and adherence to standards. A description of the state agency programs and their capacity to provide services for each population group follows.

Pregnant Women, Mothers and Infants

The Reproductive Health Program (Family Planning) provides comprehensive physical exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women and infants and children through age 4 with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the program maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. Most recently, the Immunization Program has assumed a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System.

The Newborn Screening and Genetics Services Program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. Additionally, clinic activities are provided through contracts with board certified medical geneticists for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Genetic testing, available through the Idaho Bureau of Laboratories, and counseling for pregnant women of childbearing age is also available. Medical information relative to genetics is provided through these contractors to Idaho physicians and other health care professionals involved with all segments of the MCH population.

/2004/ Genetic testing is no longer available through the Bureau of Laboratories but is available through a St. Luke's/St. Alphonsus genetics lab.

/2005/ Pediatric Endocrinology clinics will discontinue effective September 30,2004. Since September of 2003 patients have been transitioned to a new pediatric endocrinologist practicing at St. Luke's Children's Hospital.//2005//

/2009/ The Genetics Program will be adding one clinic per month. This will be done through a pilot program with the Children's Specialty Center at St. Luke's Regional Medical Center. This pilot program will run through the fall of 2008 with the intent of moving all clinics out of the State Laboratory facility and to the Children's Specialty Center. //2009//

Children

/2005/ Note: The Bureau of Health Promotion is now the Bureau of Community and Environmental Health. However, the Women's Health Check Program is now with the Bureau of Clinical and Preventive Services. The Women's Health Check Program works together with health care and insurance providers, survivors, and health educators to move forward in the fight against breast and cervical cancer in Idaho.//2005//

/2007/ The Bureau of Community and Environmental Health received funding for Comprehensive Cancer planning. //2007//

The Bureau of Health Promotion administers the Title V programs of Oral Health, Adolescent Abstinence Grant, and Injury Prevention. The non-Title V programs include several preventive health education programs: arthritis, diabetes and cancer control, i.e., tobacco prevention and breast and cervical cancer screening. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

The Oral Health Program contracts with the district health departments to perform surveys of oral health status, as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects, and school sealant projects.

The Abstinence Education Block Grant is administered from this bureau. Presently, the program has contracted with the public health districts to establish broadly based community coalitions whose members come from all segments of the community. These coalitions developed and implemented coalition action plans that address adolescent pregnancy prevention with an abstinence message. These efforts are coordinated with the Idaho Governor's Council on Adolescent Pregnancy Prevention, which is staffed by the bureau.

/2007/ Adolescent Pregnancy Prevention has been transferred to the Governor's Office.//2007//

/2008/ Adolescent Pregnancy Prevention will be transitioning from the Governor's Office back to the Department of Health and Welfare, Bureau of Community and Environmental Health, in July 2007.//2008//

The Injury Prevention Program provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions. It also coordinates public health efforts to address sexual assault prevention and suicide.

/2003/ The Injury Prevention Program works with state and local partners to provide health promotion campaigns and activities for universal use of motor vehicle safety restraints, bicycle safety, and pedestrian safety. Through the Rape Prevention Education Grant the program also addresses teen rape prevention.

/2005/ The Injury and Violence Prevention Unit work with state and local partners to develop and implement programs addressing child motor vehicle safety restraints, fall prevention for community-dwelling seniors aged 65 years and older, and rape and sexual assault prevention on

college campuses.//2005//

/2004/ The Injury Prevention Program continues to provide child safety seats and installation education with MCH funds. Also, in April 2003, the Injury Prevention Program began working with the DHW Division of Family and Community Services, Mental Health Program, the Idaho Department of Education, and community groups (SPAN-Idaho based out of Boise State University) to develop a comprehensive statewide suicide prevention plan.

/2005/ The Injury Prevention program is working to transition the child safety seat distribution and installation education to state and community partners.//2005//

/2007/ The Injury Prevention Program has transitioned successfully child safety seat distribution and installation and education to state and community partners. The program is currently focusing on fall prevention for the elderly. //2007//

/2009/ During the coming year, we will be exploring means to improve Idaho's Injury Prevention Program. This will include looking at the Poison Control program and all aspects of childhood injury. This has been an issue with Idaho's Block Grant Reviews for a number of years. We plan to be well positioned to address this in our 2010 application and 5 year needs assessment. //2009//

Children with Special Health Care Needs.

The Children's Special Health Program (CSHP) provides and promotes direct health care services in the form of family centered, community-based, coordinated care for children with special health care needs, including phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories including, neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

/2005/ In addition to CSHP, the program manager is responsible for newborn screening and genetics.//2005//

All MCH Populations

The State Epidemiologist provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. Additionally, the Deputy State Epidemiologist is engaged in providing data analysis and consultation to the Bureau of EMS to improve emergency response capabilities for pediatric patients. The EMS effort is being funded by an MCHB EMSC grant.

/2007/ The State Epidemiologist and the Deputy State Epidemiologist provide health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population.//2007//

/2009/ Robert Graff, Ph.D., a chronic disease epidemiologist, was hired by the Office of Epidemiology and Food Protection. //2009//

The STD/AIDS Program provides HIV prevention education activities as well as counseling and testing. It also distributes HIV/AIDS therapeutic drugs to eligible clients.

/2007/ Jared Bartschi oversees contractual performance of the district health departments related to STD and HIV investigations and performs analysis of epidemiologic data. Merideth Duran is involved with the different aspects of data management, including activities to assure data quality and data entry.//2007//

/2008/ Merideth Duran joined the Sexual and Reproductive Program in May 2007. The interviewing process has begun for Merideth's replacement in the Office of Epidemiology and Food Protection.//2008//

The toll-free telephone referral service, Idaho CareLine, provides information and referral service on a variety of MCH, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

/2006/ The Idaho CareLine has been designated the 211 Call Center for Idaho. Callers can now access referrals for any health and human service issue by dialing 211 or 1-800-926-2588.//2006//

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducted a Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

/2003/ Beginning with the federal fiscal year 2002 MCH Block Grant, the Perinatal Data Analyst assumed responsibility for the State Systems Development Initiative (SSDI) Grant.

/2004/ The Perinatal Research Analyst will serve as the State Data Contact for the Association of Maternal and Child Health Programs (AMCHP) and will serve on the Advisory Board for the Idaho Perinatal Project.

The Office of Rural Health and Primary Care is focused on improving services in rural and underserved areas.

/2009/ In November 2007, the Division of Health created a new bureau by uniting the Health Preparedness Program and the Office of Rural Health and Primary Care into the Bureau of Health Planning and Resource Development. Both programs are health systems focused, working closely with hospitals, federally qualified health centers, emergency medical service providers, local district health departments, associations, universities and other key players in the health system. By joining forces into this new bureau, it better integrates complementary activities, avoids program duplication and helps share vital resources, increasing the Division of Health's overall capacity for planning and supporting sustainability of health systems. //2009//

An attachment is included in this section.

D. Other MCH Capacity

All state level MCH funded personnel (with the exception of the genetics clinical personnel and the Child Mortality Review Team Coordinator (CMRT)) are located within the Department of Health and Welfare's central office building. Other Division of Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Health Promotion, the STD/AIDS Program, the WIC Program, and the Bureau of Health Policy and Vital Statistics are also housed within this same building. The Division of Medicaid Policy is housed outside the Department's central offices. Genetics clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the Bureau of Laboratories located on a separate state campus approximately three miles from the primary office building. The CMRT Coordinator's office is less than one block from central office. Distance does not deter joint

collaboration, which occurs via periodic meetings, telephone, electronic mail, and FAX communication.

A 1.0 FTE Program Manager, a 1.0 FTE Special Projects Director, and 1.0 FTE clerical specialist staff the CSHP program. In addition, services for PKU and high-risk children not covered by other service providers (WIC or EPSDT) are coordinated through CSHP. A Nutrition Specialist provides 0.4 FTE technical support to CSHP to assure PKU and special nutritional needs are met.

/2009/ The CSHP Special Projects Director position has been reclassified to and Registered Nurse, Senior Position. The position remains 1.0 FTE. //2009//

/2006/ The CSHP Manager is responsible for the management aspects of the genetics program as well as for newborn screening. A full time administrative assistant and part-time genetics counselor coordinate genetic clinics, counseling, diagnosis and follow-up care to women, infants and children.//2006//

/2004/ The Newborn Screening and Genetics Program Manager resigned this past Spring. Plans to fill the position or transfer program responsibilities to CSHP are pending the decision on whether or not the agency will maintain the FTE.

A 1.0 FTE program coordinator and a 0.5 FTE secretary staff the Oral Health Program.

The 1.0 FTE MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Health Policy and Vital Statistics.

The toll-free telephone referral line is supported by 1.0 FTE Community Services Coordinator and 4.0 FTE Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

/2006/ The CareLine is now supported by a 1.0 FTE Community Services Coordinator and 6.5 FTE Customer Service Representatives.//2006//

/2007/ The CareLine is supported by a 1.0 FTE Program Supervisor and 9.0 FTE Customer Service Representatives.//2007//

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health, Epidemiology, Immunization, Reproductive Health, and Genetics Services. Within the Bureau of Health Promotion programs receiving MCH Block Grant funds are: Injury Prevention and Oral Health Promotion. The Health Statistics section of the Bureau of Health Policy and Vital Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Council for the Deaf and Hard of Hearing receives funding via a contract with the Title V Agency, and the Idaho CareLine receives direct MCH block grant funding.

/2003/ The Office of Epidemiology was created in 2001 and reports directly to the Administrator of the Division of Health.

/2004/ The Immunization Program no longer receives block grant funds. The Bureau of Emergency Medical Services receives funds for the part time CMRT Coordinator position.

/2008/ Idaho lost TANF funding that was being used to support outreach and education efforts in the Immunization Program. The Division of Health is in discussions with the seven health districts to shift MCH funds within the Bureau of Clinical and Preventive Services programs in order to cover this shortfall. //2008//

/2009/ Title V funds have supported the Immunization Program during the past year. //2009//

/2006/ The child mortality team has been disbanded. //2006//

There are a number of other programs within the Department of Health and Welfare that are tied in varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Health Promotion receives MCH funds via the Abstinence Grant. This has also been true of the Bureau of Emergency Medical Services which has received an MCH grant for children's injury surveillance. Also, the Health Statistics Program of the Bureau of Health Policy and Vital Statistics is now administratively responsible for the SSDI grant.

/2005/ Idaho's breastfeeding promotion and support initiatives receive MCH funds periodically.//2005//

In addition to having funding ties to MCH programs there are a number of other programs with the umbrella Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the STD/AIDS program; within the Bureau of Health Promotion: the Breast and Cervical Cancer Early Detection program, the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention programs; within the Bureau of Health Policy and Vital Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, and the Infant Toddler program.

/2005/ Breast and Cervical Cancer Early Detection program is now within the Bureau of Clinical and Preventive Services and known as the Women's Health Check Program.//2005//

/2006/ The Adolescent Pregnancy Prevention program is now with the Office of the Governor.//2006//

/2008/ In July of 2007, Adolescent Pregnancy Prevention will be transferred from the Governor's Office to Department of Health and Welfare, Bureau of Community and Environmental Health.//2008//

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This agency provides much of the important data used in program assessment including providing data on health insurance as well as that which defines access to care issues. Also, each of the seven District Health Departments have very strong ties to each MCH program through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

E. State Agency Coordination

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

Formal agreements exist between the Divisions of Health, Family and Community Services, and Medicaid. These agreements refer to relationships of the three divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, Early Intervention Services through

the Infant Toddler Program, Special Education Services under the Individuals with Disabilities Education Act, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V (Maternal and Child Health Block Grant) Program, the Title X (Family Planning) Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Recent collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on integrating MCH prevention activities into the Medicaid Managed Care system, clinic services for the CSHP Program, and enhancement of Medicaid for the family planning services. Additionally, collaboration with the Division of Welfare has contributed TANF funding for public health programs, i.e., the statewide immunization registry and related media promotion.

/2004/ During FY 2002, the MCH Oral Health Program, Medicaid, and the districts worked together to obtain provider status to allow reimbursement for preventive dental services provided by dental hygienists employed by the districts.

/2005/ During FY 2003, the MCH Oral Health Program and Medicaid engaged in ongoing discussions regarding early childhood caries prevention and the potential for integrating oral health with primary medical care through the Healthy Connections managed care program. Idaho Medicaid will reimburse physicians, physician's assistants and nurse practitioners for fluoride varnish application for children age 21 and younger. //2005//

/2006/During FY 2004, legislation changing the Idaho State Dental Practice Act was enacted, creating an extended access endorsement for dental hygienists allowing preventive dental hygiene services to be provided under general supervision in public health settings and allowing retired dentists to provide clinical dental services on a volunteer basis in non-profit dental clinics. Medicaid analyzed the potential cost impact if direct reimbursement were allowed to extended access endorsed dental hygienists. Currently, only district health departments or other entities that employ a dental hygienist can receive Medicaid reimbursement./2006/

/2007/During FY 2005, Idaho was one of 13 states selected to send a team to the CHCS Purchasing Institute Best Practices for Oral Health Access, held in Philadelphia in September 2005. The MCH Oral Health Program worked with the Division of Medicaid to develop the Idaho application. Information gained at the CHCS Purchasing Institute was timely and useful in developing the oral health component of the proposed Idaho Medicaid Modernization, which emphasizes prevention and disease management.//2007//

/2006/ Women's Health Check cooperates with the Divisions of Medicaid and Welfare to provide treatment for women diagnosed with breast or cervical cancer.//2006//

As indicated in the FY 1996 application, the re-organization that occurred aligned several Title V programs with programs which share complementary services and common target populations within the same Bureau. Included among these are the WIC Program which formally screens clients for referral to Title V programs. The WIC Coordinator attends the Title V staff meetings. Interactions also occur on an informal basis at the state and district level. The WIC Program has assumed the lead on the performance measure related to breast-feeding.

A formal agreement between Title V and the Title X Family Planning Program is unnecessary. These two federal programs jointly fund the Reproductive Health Program. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

Cooperation between the Reproductive Health Program (Title V addressing teens) and the STD/AIDS Program regarding the Infertility Prevention Program is documented in a file letter. The letter verifies a formal contractual agreement with the districts and the Bureau of Laboratories to provide STD testing. Both of these programs reside within the Bureau.

The Bureau of Clinical and Preventive Services enjoys a traditional as well as efficient collaboration with the Bureau of Health Promotion with the latter having once been an organizational component of the former. This bureau provides health promotion activities for injury prevention, adolescent pregnancy prevention, breast and cervical cancer prevention, tobacco prevention, oral health promotion, diabetes control, arthritis, and rape prevention. The Bureau of Health Promotion collaborates with the Title V agency to impact those performance measures dealing with suicide, adolescent pregnancy and protective sealants.

/2009/ Several years ago, the Bureau of Health Promotion was combined with the Bureau of Environmental Health to form the Bureau of Community and Environmental Health. //2009//

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated Idaho CareLine. This service is administered through the Division of Family and Community Services.

Interagency agreements are reviewed on a periodic basis, depending on the expiration date of an interagency agreement if there is one, and subject to the cooperative relationships that these cooperative agreements represent.

Councils, Coalitions, and Committees (State and Non-State Agencies)

In addition to the formal agreements mentioned above, the MCH program staff serve on many committees and advisory boards, including but not limited to:
a) The Supplemental Security Income (SSI) Committee, an interagency group with goals to explore the development of a common application form; to disseminate SSI application information to physicians, teachers and parents; to identify and address transition issues for adolescents; to educate parents about the application process.
b) The Medical Authorization Review Subcommittee of the Children's Special Health Program Medical Advisory Committee, reviews requests for authorization services from health districts and to advise staff regarding CSHP policies and operational procedures.
c) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
d) The Idaho Infant Toddler Interagency Coordinating Council which provides leadership in the implementation of the Individuals with Disabilities Education Act (IDEA), Part C.
e) Comprehensive School Health Taskforce, to assist in improving the capacity of Idaho communities to enhance the health of their young people.
f) Healthy Child Community, an interdepartmental group interested in promoting the health and well being of the MCH population by increasing public awareness of the importance of early and continuous prenatal and well child care.
g) Idaho Coalition for Health Education (ICHE), a network of individuals and organizations promoting health/wellness through quality health education in schools, work sites, and communities.
h) Idaho Breast and Cervical Cancer Alliance (IBCCA), dedicated to reducing the risk and impact of breast and cervical cancer through partnerships focusing on education, early detection, comprehensive care and disease monitoring.
i) Emergency Medical Services for Children Taskforce, an MCH-funded project designed to reduce child and youth disability/death due to severe injury or illness through insuring the availability of state-of-the-art emergency medical care.
j) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse, this project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.

k) Idahoans Concerned with Adolescent Pregnancy is a statewide public/private partnership organized in 1989 by the Bureau of Maternal and Child Health to reduce the rates of teen pregnancy and the adverse effects of adolescent pregnancy on teens, their families and children. /2005/ This group is no longer a functioning partnership. //2005//
l) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families. Through an agreement, CSHP receives notification from DDS on both SSI approved and ineligible clients. CSHP uses the notifications as a case finding tool and as a means of ensuring eligible clients successfully apply for SSI benefits.
m) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
n) Idaho Governor's Council on Adolescent Pregnancy Prevention. /2008/ Disbanded by the Governor.//2008//
o) Idaho Newborn Hearing Screening Consortium provides funding for technical assistance to birthing hospitals for screening of newborns, provides public awareness, and collects statewide data.
p) Sexual Assault Prevention Advisory Committee develops media messages targeted at parents with young children for date and acquaintance rape prevention.
q) Idaho State Child Mortality Review Team reviews deaths of all Idaho resident children under 18 who die in Idaho with recommendations for preventing future child deaths. /2006/ This group is no longer active.//2006//
/2004/
r) Terry Reilly Health Service Dental Advisory Committee, which provides guidance for funding, volunteer networking and operation of the community health center dental clinics. /2006/ Committee no longer meets./2006/
s) Idaho Dental Hygienists' Association Community Outreach Committee, which seeks to expand access to oral health services through community projects and partnerships organized and/or conducted by the local component dental hygiene societies.
t) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
u) Action for Healthy Kids is a statewide initiative dedicated to improving the health and educational performance of children through better nutrition and physical activity.
v) Healthy Weight Steering Committee is a diverse group with an interest in nutrition and physical activity. This group applied for and received funding from the Office of Women's Health, Region X, to conduct focus groups with postpartum women on issues related to weight and a statewide meeting on the issue of obesity in Idaho. /2007/ With the establishment of the Idaho Physical Activity and Nutrition Program, this committee no longer meets. Most participants now partner with the IPAN program.//2007//
w) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT Book and related efforts to track and promote the well-being of children in Idaho through research, education and mobilization strategies.
x) Friends of Children and Families Head Start Health Advisory Committee. /2006/
y) Association of State and Territorial Dental Directors Data Surveillance Committee. /2006/
/2009/

- ***Early Childhood Coordinating Council***
- ***Developmental Disabilities Council***
- ***Idaho Immunization Congress -- a grassroots effort to start and establish a statewide immunization coalition***
- ***Early Years Conference //2009//***

Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health

education, physical health, environmental health, and public health administration. Some of the specific activities include: school health visits, prenatal and child health visits, immunizations, adult health visits, family planning services, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services.

The Title V agency implements program strategies through contracts with the public health districts. Indeed, the core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Health administration and staff meet monthly with the Directors of the district health departments.

Federally Qualified Health Centers/Community Health Centers

The Office of Primary Care, formerly of the Bureau of Health Policy and Vital Statistics, has a cooperative agreement with the Idaho Primary Care Association to help expand access to primary care in Idaho. As the FQHCs and CHCs often represent the only health care available in rural areas, past agreements have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer. Additionally, the Immunization Program maintains contracts with several FQHCs to provide immunization status assessments of their clinics as well as identifying barriers to immunization.

/2005/ The Reproductive Health program has an MOU in place with Family Health Services, a Community Health Center in Twin Falls, to pilot providing contraceptives to low income women in rural clinic sites. //2005//

/2006/ The MOU between Family Health Services and the Idaho Reproductive Health Program is currently in place until January 2006 when progress will be re-evaluated. Success of this partnership has been demonstrated by the 717 clients seen in CY04. In the first quarter of CY05, Family Health Services reported 421 clients have been seen in their clinics for reproductive health care. Eighty-two (82) percent of these clients reported incomes of less than 100 percent of the federal poverty level. An MOU is also in place between Southeastern District Health and Healthwest, a community health center, in Pocatello, Lava Hot Springs, and Downey, Idaho. Clinics in Lava Hots Springs and Downey serve an area with limited pharmaceutical services.//2006//

/2008/ The MOU's with community health clinics has been discontinued since the clinics can access 340(b) pricing directly.//2008//

Universities

The Division maintains a relationship with all three of Idaho's universities. Past projects have included a survey of high-risk populations for the HIV/AIDS Program by the University of Idaho and a survey of medical providers for the Office of Primary Care by Boise State University. The State Epidemiologist collaborated with Idaho State University on a CDC grant to study efficacy of the pertussis vaccine in outbreaks in Idaho. That university has also been a contractor with the Immunization Program to conduct assessments of the immunization status of patients seen in physician offices throughout the state. In 1999, the Title V agency collaborated with the Institute of Rural Health Studies (IRHS) at Idaho State University to develop a grant application to impact on alcohol use in pregnancy. During FY 2000, the University of Idaho was under contract to provide services related to the newborn hearing screening consortium. Currently, the Immunization Program is contracting with Boise State University and Idaho State University to provide student interns to private immunization providers to assist with the implementation of patient reminder/recall systems for their immunization patients.

/2005/ The Immunization Program no longer contracts with these universities as this program is

already implemented.//2005//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	28.0	28.0	20.0	18.3	16.0
Numerator	145	153	111	100	91
Denominator	51875	54629	55482	54564	56950
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data reflects Medicaid and Idaho CHIP enrollees only. General hospitalization data not available.

Notes - 2006
Data reflects Medicaid and Idaho CHIP enrollees only. General hospitalization data not available.

Narrative:
Idaho does not have hospital discharge data available, so we do not know the discharge rate for children or adults.

In an attempt to address the known contributors to hospitalizations among children (lack of knowledge among care providers, lack of access to medications during school hours, environmental triggers, and in-appropriate diagnosis and treatment), the Idaho Respiratory Health Program (formerly known as the Idaho Asthma Prevention and Control Program) and its partners, Asthma Coalition of Idaho, American Lung Association, Indoor Air Program, Idaho Department of Education, and School Nurses Organization of Idaho, are working with schools to increase awareness among and efficacy of school staff and has developed the School Asthma Management Model for Idaho (SAMMI) that was distributed to all schools in Idaho. SAMMI is an administrative, policy, and educational tool. SAMMI will be evaluated and updated by August 2009, and a tool similar to SAMMI will be designed for and distributed to childcare facilities and preschools. The Respiratory Health Program and its partners successfully passed legislation to allow children to carry their asthma inhalers and self-medicate while at school. The Respiratory Health Program and the American Lung Association are partnering to provide the Open Airways for Schools program statewide, and the Respiratory Health Program and the Indoor Environment Program are providing Tools for Schools assessments statewide. Over 250 child care providers have been educated in the management of asthma, and approximately 50 health care providers statewide have been trained in the appropriate diagnosis and treatment of asthma. Additionally, the Respiratory Health Program has trained over 300 Head Start staff and 300 Head Start parents in methods to decrease exposures to asthma triggers in the home. The Respiratory Health Program is working to reduce bus and other vehicle idling at schools.

We will continue to educate health care providers through an Asthma Educator Institute with the American Lung Association of Washington, and by systematically promoting the newly revised National Heart, Lung, and Blood Institute (NHLBI) guidelines to all health care providers statewide.

While there is no way to know what impact these interventions may be having on hospitalization rates for children, they are all based on best practices, and have been shown to assist other states in decreasing asthma-related hospitalization rates.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	70.5	72.6	70.5	68.9	69.0
Numerator	15706	16985	16834	15798	16145
Denominator	22276	23406	23865	22930	23393
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Data Source:

Medicaid

Narrative:
The Division of Medicaid is continuing to work on a project that educates parents and providers regarding well baby clinics, reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	42.9	42.0	38.7	43.3	43.6
Numerator	210	235	222	632	1156
Denominator	490	559	574	1460	2652
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data Source: Medicaid

Notes - 2006
Data Source: Medicaid

Notes - 2005
Data Source: Medicaid

Narrative:
The Division of Medicaid continues to work on a project that educates parents and providers regarding well baby clinics. reminding them that check-ups are for when the child is well. Education is also being done with data entry staff so that coding is done properly. We will work with Medicaid and monitor this closely as Medicaid Modernization is implemented in Idaho.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	76.8	74.2	74.2	74.0	72.7
Numerator	15955	15814	16421	17230	17571
Denominator	20777	21314	22142	23296	24160
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

Birth records for 2007 not finalized as of date of entry.

Notes - 2006
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began data may have been estimated from mother's recollection or based on information in mother's medical record.

Notes - 2005
2005 data not available until September 2006.

Narrative:

Data are for Idaho resident births and are based on records with known data for calculating the Index.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	94.3	92.5	87.1	88.6	86.2
Numerator	142394	150105	128422	124117	125596
Denominator	151017	162240	147366	140163	145682
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2007
Values reflect numbers of children aged <=19.

Notes - 2006
Values reflect numbers of children aged <=19.

Narrative:
Medicaid data indicate a downward trend from 2004 and 2005 with a slight increase in 2006. It may be difficult to interpret this change as Medicaid reform is implemented. We will watch this indicator closely as changes are made to Idaho's Medicaid system.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	48.0	49.2	51.0	55.5	43.3
Numerator	14952	16759	15345	19392	17821
Denominator	31177	34068	30069	34939	41156
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data Source: Medicaid
Includes Medicaid and Idaho CHIP enrollees only.

Notes - 2006

Data Source: Medicaid
Includes Medicaid and Idaho CHIP enrollees only.

Narrative:
Medicaid is reimbursing doctors and midlevel providers for topical fluoride applications. Data is from Medicaid. As Idaho implements the Medicaid Modernization Program there will be changes as Medicaid contracts with Blue Cross to cover dental services.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	3077	1949	3244	1194	1261
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. That is the payment source, rather than Title V, for all rehabilitative services needed.

Incidence data from SSA via Health & Ready to Work website:
www.hrtw.org

Notes - 2005
All children who receive SSI in Idaho automatically qualify for a medical card through Idaho Medicaid. That is the payment source, rather than Title V, for all rehabilitative services needed.

Incidence data from SSA via Health & Ready to Work website:
www.hrtw.org

Narrative:
Always 0 since CSHP only provides insurance coverage equivalent for children with no creditable health insurance.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight	2007	payment source	7.3	5.9	6.6

(< 2,500 grams)		from birth certificate			

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	payment source from birth certificate	6.5	6.2	6.8

Notes - 2009
Death records for 2007 not finalized as of date of entry.

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	61.8	76.8	71.7

Notes - 2009
Birth records for 2007 not finalized as of date of entry.

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid,***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	65.9	76.4	72.7

Notes - 2009
Birth records for 2007 not finalized as of date of entry.

Narrative:
Birth certificate data from Vital Statistics.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	185

Narrative:
Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all chidren's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:
1) low-income children and working-age adults
2) individuals with diabilities or special health needs, and
3) elders or those otherwise dually eligible for Medicaid and Medicare.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 19)	2007	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 19)	2007	 185 185 185

Narrative:
Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all chidren's Title XIX and XXI programs.

Idaho Medicaid is creating tailored benefit plans for:
1) low-income children and working-age adults
2) individuals with diabilities or special health needs, and
3) elders or those otherwise dually eligible for Medicaid and Medicare.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	100

Notes - 2009
Pregnant women are not covered by SCHIP in Idaho unless the woman qualifies as a child. 100% entered because the form requires a value in the range 100-500.

Narrative:
Medicaid and SCHIP eligibility requirements. The eligibility requirements have changed with the implementation of Idaho's Medicaid Modernization plan. Eligibility gaps in service coverage have been eliminated by adopting the Idaho Medicaid benchmark benefit packages. Additionally, Idaho removed the asset test (resource limit) from all chidren's Title XIX and XXI programs.

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1) low-income children and working-age adults
2) individuals with diabilities or special health needs, and
3) elders or those otherwise dually eligible for Medicaid and Medicare.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES	3	Yes

Annual linkage of infant birth and infant death certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	No

Notes - 2009
Pilot tests linking birth certificates and WIC data are being conducted in 2008.

Idaho PRATS survey is conducted annually. Direct access to data is not available to MCH but a close working relationship allows detailed analysis to be performed at MCH request.

Pilot tests linking birth certificates and Medicaid claims data are being conducted in 2008.

Narrative:
The manager of the PRATS program is working on a project linking WIC data, birth certificates and PRATS data.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2009

Narrative:
A weighted YRBS survey was conducted in Idaho in 2005, 2003 and 2001.

In 2005, the total percentage in reporting tobacco use in the past month was 21.4% (Males - 27.1% and Females - 15.9%). In 2003, total use was 17.8% (Males - 20.3% and Females - 15.0%), in 2001 the total was 23.4% (Males - 28.3% and Females - 18.0%). Data source is the CDC website. See State Performance Measure 4 for activities.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Idaho's priorities for its MCH population continue to be based primarily on the results of the 5 year needs assessment conducted five years ago.

The health needs of pregnant women are: Substance Abuse, Domestic Violence, Prenatal Care, and Access to Care. The indicators for pregnant women are focused around the following topics: Breastfeeding, delivery, prenatal care, maternal mortality, tobacco and alcohol use (expanded to include drug abuse), maternal morbidity, access to care (which includes health insurance issues) and miscellaneous topics, such as unintentional pregnancies, births to not married adults, postpartum depression, and domestic violence.

The health needs of infants are: Child Abuse, Immunizations, Improving access to care and Disparities in infant mortality. Health Insurance was folded into the Access to Care issue, and data for Newborn Screenings, hearing and metabolic show that Idaho is doing a good job of screening infants. Indicators for infants are focused around the following topics: newborn screenings, mortality, birth weight, access to care/health insurance, and morbidity.

The health needs of children are: Child Abuse, Immunizations, Access to Care, Unintentional Injury (Morbidity and Mortality due to), and Dental Disease. Obesity was also considered, but ranked lowest among the other priorities. Idaho does not have state-specific obesity data for children, but relied upon the limited national data that is available. Indicators for children are focused around the following topics: immunizations, oral health, mortality, access to care/health insurance, morbidity, and abuse/injury.

The health needs of adolescents are: Substance Abuse, Abuse, High-Risk Teen Behavior (markers of high risk teen behavior are STD rates, suicide, violence and teen pregnancy), Access to Care and Teen Pregnancy. Indicators for adolescents are focused around the following topics: teen pregnancy, alcohol, tobacco and drug use, diet and exercise, health screenings, sexual behavior and STD's, school violence, the school dropout rate, and the juvenile arrest rate for violent crimes.

As with many states, determining an accurate count of children with special health care needs is difficult. The lack of population based data was evident during the needs assessment process. Access to Care, however, is the highest priority need for this population. The other two issues considered are availability of specialty care and inadequate data. Indicators for Idaho's CSHCN population are focused around the following topics: Programmatic data concerning the medical diagnostic categories for individuals served, examples of medical conditions not covered by Idaho's program, the federal definition of "children with special health care needs" and estimates of how many children in Idaho potentially fall into this category.

The Title V Maternal and Child Health Block Grant directly funds programs and support services to address most of the issues identified as priority areas for Idaho's MCH population. They include: Reproductive Health, Children's Special Health Program, Oral Health, Epidemiology Services, Genetics, Newborn Hearing Screening, Perinatal Assessment, Injury Prevention, Child Mortality Review Team, Suicide Prevention, MCH Research and Data Analysis, and the Idaho CareLine.

/2006/ Idaho has just completed it's 5 year needs assessment. A contractor, Health Systems Resarch, performed the needs assessment. The assessment included several meetings with key stakeholder, key informant interviews, focus groups, general and population specific surveys, review of secondary data and a capacity assessment among state level MCH personnel. Priority needs are listed in the next section. //2006//

B. State Priorities

1. To reduce infant mortality and low birth weight by reducing unintended pregnancies through family planning services.
2. To reduce the adolescent pregnancy rate through improved access to contraceptive services.
3. To increase health education on substance abuse and physical abuse issues to pregnant women, mothers and adolescents.
4. To increase access to care including oral health - (not limited to focusing on health insurance) - targeting women, infants and children and children with special health needs.
5. To increase prenatal care utilization focusing on population disparities.
6. To reduce vaccine preventable diseases by increasing the immunization rates of children 0-2 years of age.
7. To reduce morbidity/mortality due to injury.
8. To reduce behaviors in adolescents such as suicide and risky sexual activities leading to teen pregnancy and STD's.
9. To reduce infant morbidity/mortality by review of infant/child deaths by the Child Mortality Review Team, followed by targeted interventions.
10. To increase capacity for "cluster" investigation/surveillance and to increase data capacity for all MCH populations.

/2006/ Below is a list of priority areas that were identified during Idaho's 5 year MCH needs assessment. They are not in order of priority, but rather a list of the 10 key areas needing attention.

Priorities:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for pregnant women and children across provider and community networks.

2. Perinatal Depression: Identify screening tools and work with state professional groups and the regional perinatal coalitions to develop mechanisms to assure appropriate use of the tools and availability of referral resources for perinatal depression.

3. EPSDT screenings: Develop strategies to assure that EPSDT screenings and follow up are occurring as appropriate for all infants, children and adolescents.

4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.

5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex care needs of all CSHCN.

6. Cultural Competency: Improve cultural competency across all programs that work with the Maternal and Child Health population.

7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.

8. Health Education: Strengthen health education in the public schools, including developing strategies to assure that school health educators receive up to date training on health topics.

9. Systems Development: Develop and strengthen existing system collaboration efforts that focus on defined outcomes for the MCH population. Start building the infrastructure within MCH programs to sustain efforts over time and work to include all MCH partners when planning and targeting efforts.

10. Overweight and obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children. //2006//

/2008/ A number of factors over the past year have greatly influenced Idaho's MCH Title V program and the state priorities that were identified in the 2006 application. Below is a list of state priority areas that currently reflect the need of Idaho's MCH population. These are not in priority order; they are presented as a list of 7 key areas needing attention.

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.

2. Public Health will work with Medicaid to explore options to maximize services to the MCH population.

3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.

4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2 years of age.

5. Work with Medicaid, the newly formed Division of Behavioral Health and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.

6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.

7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy. //2008//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100

Annual Indicator	95.0	100.0	100.0	100.0	100.0
Numerator	19	16	28	17	31
Denominator	20	16	28	17	31
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

/2008/ In July of 2007 Cystic Fibrosis was added to the NBS test battery. //2008//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide education/technical assistance to birthing facilities and midwives in all regions of the state.			X	X
2. Hired a new "Nurse, Registered Senior" to backstop the NBS program, and to help resolve lost-to-follow-up cases.		X	X	X
3. Continue to use telemedicine visions for Idaho families in remote areas, to interact with specialists from Oregon.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2008/ In April of 2008 an RN was hired to provide clinical advice and follow-up support for the Newborn Screening Program. In addition, the RN will be coordinating and/or conducting in-service trainings at birthing facilities around Idaho to improve NBS practices. //2008//

c. Plan for the Coming Year

/2008/ As the new RN settles in to her position, a formal and regular schedule of NBS in-service trainings will be created to ensure a steady level of support to birthing centers around Idaho. The program continues to consider the possibility of using a contractor to do some of the provider education, but this option has been delayed by at least a year.//2008//

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	60	60	60	60

Annual Indicator	57.2	57.2	57.2	57.2	52.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	53	53	53	53	53

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2008/ With the Program Manager position unfilled for part of 2007, and the training/learning time of the new manager, the accomplishments for PM02 in 2007 were modest. However, some the program is able to report some successes.

- CSHP provided some financial support to Idaho Parent's Unlimited.
- Mitch Scoggins has joined the Advisory Board of Idaho Parents Unlimited (IPUL) to serve at the state representative to this family group.
- A family representative attended the annual meeting of the Western States Genetics Collaborative along with the CSHCN program manager and the genetic counselor. //2008//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner with advocacy organizations to provide technical assistance and funding support.		X		X
2. Participate in the Developmental Disabilities Council and the Early Childhood Coordination Council, which include fmaily members.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2008/ In addition to the IPUL Advisory Board which is an ongoing commitment, the CSHCN program manager also serves on the Idaho Sound Beginnings advisory board and the Developmental Disabilities Counsel. //2008//

c. Plan for the Coming Year
/2008/ Idaho's CSHP program is undergoing a period of significant change, with new staff and new program methodology. As the program mutates the input of families will be actively sought. Through participation on advisory counsels and boards, interaction with patients and families in clinical settings, mailings, and phone conversations, the program will seek to constantly sample family thoughts and ideas. //2008//

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	50	52	52	52	52
Annual Indicator	49.1	49.1	49.1	48.8	47.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	52	52	52	52	52

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2008/ The recently released CSHCN survey showed a slight drop (1.1%) for this PM. Currently and historically CSHP has not been involved in any efforts to promote the medical home concept in Idaho. The fact that this PM is reported at 47.7% is a tribute to the desire by Idaho's physicians to provide excellent services to their patients. //2008//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Primarily due to the efforts of the AAP and AAFP, with limited CSHP financial support over the last few years - the new survey of CSHCN shows that Idaho has made significant headway on this indicator. However, CSHP remains only tangetially involved		X	X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2008/ There are no current activites within CSHP attempting to impact this indicator. //2008//

c. Plan for the Coming Year

/2008/ The medical home concept is difficult to understand, and exponentially more difficult to try to implement by anyone other than a medical practice. This is one area where Idaho's CSHCN program is in need of some technical assistance, and the TA section of this document will reflect this need. //2008//

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective		60	60	60	60
Annual Indicator	53.3	53.3	53.3	53.3	56.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	60	60	60	60

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2008/ According to the recently released CSHCN survey, there was a 3.6% improvement in this PM over the last five years. In 2003 Idaho was 6.7% away from meeting the performance target of 60% for this PM. That gap has been reduced by 46% to only 3.1%.

CSHP continues to provide condition-specific coverage for Idaho's children within certain diagnostic categories, which has a slight positive impact on this indicator. //2008/

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to use CSHP Summit participants in efforts to identify options for un-and under-insured special needs families		X		X
2. Continue attempts to work with Medicaid and Welfare staff to enroll uninsured kids into Medicaid programs.		X		X
3. Idaho's legislature passed a rule this year which prohibits insurance companies from applying a "pre-exisiting condition" clause to infants born with any sort of birth defect or error of metabolism.		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2008/ CSHP is currently working with the Divisions of Medicaid and Welfare to review the file of each of CSHP's current patients to determine whether or not the child is potentially Medicaid eligible. For children who are determined to be potentially eligible, a CSHP contract will work directly with the families and serve as a liaison to assist the families in applying for Medicaid coverage for the child.

Idaho's Division of Welfare has recently developed a "child only" Medicaid application which is short, simple and requires only the minimum documentation for consideration. It is anticipated that this streamlined process will reduce the barriers to access for some families and enable them to get better coverage for this children. //2008//

c. Plan for the Coming Year
/2008/ Once the initial case load of CSHP is reviewed in an effort to get patients on to Medicaid, CSHP will systemize the practice of using the child-only Medicaid application. As part of the CSHP application process, each family who applies to CSHP will be required (and assisted) to apply for Medicaid coverage. Since CSHP only pays condition-specific medical claims, enrolling the child in Medicaid instead offers the possibility of more holistic health coverage for the child. //2008//

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	77	80	80	80	80
Annual Indicator	75.2	75.2	75.2	75.2	85.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	86	86	86	86	86

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2008/ The recently released CSHCN survey showed a significant increase in this PM, a jump of 10.7%. This has resulted in Idaho having exceeded its target of 80%, by almost 6%. While CSHP is delighted to see such a marked improvement in this PM, we cannot lay claim to many activities leading to this improvement. CSHP does endeavor to provide highly organized and family-friendly direct-service clinics, and our exit surveys have shown that we have been successful. However, since we only see a few hundred children annually at all of our direct-service clinics combined, we are uncertain about the significance of our contribution to the huge increase in this PM. //2008//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use and build upon existing relationships with advocacy and support organizations to provide educational and information materials through meetings, conferences and newsletters.		X		X
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2008/ Apart from practicing continuous quality improvement in the clinics CSHP operates either directly or by contract, there are no ongoing activities related to this PM. //2008//

c. Plan for the Coming Year
/2008/ CSHP is planning to make a strategic move down the MCH pyramid by divesting itself of its current direct-service clinics and instead financially supporting private medical providers/institutions to provide those services. It is believed that by switching service provision over to the existing medical establishment, CSHP's patients will be served more appropriately, more conveniently, and the services will be more community-based. //2008//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6	6	6	6	6
Annual Indicator	5.8	5.8	5.8	1	45.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	46	46	46	46	46

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. Prior years reported the national measure rather than Idaho's measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
/2008/ It would appear that there was a tremendous increase in this PM in the last few years, but since this question in the two CSHCN surveys are not comparable, we cannot really know what impact has been made. //2008//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Have made contact with Idaho's Division of Voc Rehab to participate in their transition to adulthood conference this year.		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2008/ There are no current activities by CSHP working toward impacting this PM //2008//

c. Plan for the Coming Year
/2008/ CSHP is trying to form a partnership with the Idaho Assistive Technology Project which is the preeminent organization in Idaho working on transition-to-adulthood issues for special needs children. Instead of starting possibly parallel activities, CSHP would prefer to work with the IATP to form a symbiotic relationship. //2008//

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	77	80	81	82	83
Annual Indicator	79	80.8	78.1	77.8	77.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	83	83	83	83	83

Notes - 2007

NIS data for CY2007 is not available until August, 2008. 2006 value used as estimate for 2007, Four or more doses of DTaP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB

The percentages come from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2006
NIS data for CY2006 is not available until August, 2007
The percentages come from the National Immunization Survey. No numbers are given as to how many were surveyed or how many are completely immunized.

Notes - 2005
NIS data for CY 2005 is not available until August, 2006.

a. Last Year's Accomplishments
The Idaho Immunization Program (IIP) completed provider education conferences this past year. These are regional conferences held throughout the state focused on: vaccine management and safety, provider education, reminder/recall of patients due for immunizations, and parent education. The Program also continues to have a very strong WIC linkage for screening and referral of WIC clients to immunization services. This includes screening every WIC child's immunization record to verify they are up-to-date. The program also continued to monitor immunization coverage levels within the Medicaid population.

The IIP conducted quality assurance reviews with 130 VFC providers in 2007. IIP was unable to meet the goal of visiting all Vaccines For Children (VFC) providers due to staffing shortages. Strategic planning for the program was completed in 2007. The program was able to secure funding from the state legislature for influenza vaccine; this will enable the program to continue offering influenza vaccine universally.

The IIP continued to offer immunization training opportunities to medical assistant and nurse training programs through the state.

The IIP has over 31 data exports from provider electronic health records into the Immunization Reminder Information System (IRIS) and is continuing to work on 5 additional systems that have the potential to impact another 21 providers.

The IIP provided all vaccines, except HPV vaccine, free of charge for children 0 through 18 years of age at public and private provider sites throughout Idaho. The IIP also implemented a Delegation of Authority with public and private VFC providers in 2007. This allows the underinsured children to receive non-universal vaccine at any VFC provider office and promotes keeping children in their medical home. The IIP continues to see a rise in the number of children receiving the following vaccines: Pneumococcal (PCV), Polio, MMR (measles, mumps and rubella), and Hepatitis B.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free vaccine to all children 0 through 18 years of age by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.			X	
2. Perform annual site visits to VFC providers and conduct provider education.			X	
3. Provide parent, school and daycare education, media and			X	

training.				
4. Maintain an immunization registry, which includes data quality monitoring.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The IIP is working with health departments and community migrant health centers to make access to immunizations more available to parents by providing vaccines at no cost. The program is working closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the IIP has developed a strategic plan for improving immunization coverage levels. As part of the strategic plan, the IIP has re-developed the Quality Assurance program so that it targets immunization providers that do not have a minimum of 80% coverage level for the 4:3:1:3:3:1 (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella) immunization series. Providers that do not have at least an 80% coverage rate will receive an action plan developed by the Quality Assurance Specialist (QAS) in conjunction with the provider. The IIP will be rolling out an aggressive media campaign aimed at increasing immunization rates beginning in late 2008. The IIP also plans to visit approximately two-thirds of all VFC providers in 2008 with Quality Assurance Reviews (QAR).

The IIP is in the process of developing standardized training materials for IRIS and health department staff will be trained in July using the new materials. The IIP is working on exports from provider electronic health record systems into IRIS with approximately 21 providers throughout the state.

c. Plan for the Coming Year
The IIP will continue to provide universal vaccines to children 0 through 18 free of charge to the public and private providers in the state. The development of proactive strategies to sufficiently fund a universal vaccine plan are currently underway.

The IIP will implement a strategic plan targeting increasing immunization rates. Regional and local training conferences will also continue to encourage, educate, and reward providers for their efforts. In addition, the IIP will expand its training efforts of medical assistants and nurses.

The Immunization Program will continue to work with health departments, private providers, and community migrant health centers to make immunizations more available to parents. The program will continue to work closely with the WIC program to screen clients for immunization status and refer those not up to date to their health care provider.

During CY 2009, the IIP will contract with the district health departments to investigate reported cases of hepatitis B surface antigen positive pregnant women and ensure the newborns are appropriately vaccinated at birth. The program will also implement and maintain a new registry, including a tracking and recall system, to assure that the infants complete the hepatitis B vaccine series. The IIP will continue the Hospital Quality Assurance Program that addresses standing orders for the birth dose of hepatitis B vaccine.

Additionally, during CY 2009, the IIP will continue a population-based implementation program to

increase Hepatitis A and Varicella immunizations by: (1) targeting children 1 to 18 years of age to have two doses of hepatitis A vaccine and 2 doses of Varicella; and (2) providing all vaccines at no cost as part of its general statewide distribution.

In an effort to impact the national objective of 90% immunization rates for children aged 2 years, the IIP will continue to conduct or contract for activities in four major areas: (1) parent education, (2) provider education, (3) reminder/recall, and (4) childcare and school education.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	16	15	14	13	15
Annual Indicator	17.5	16.8	16.8	17.9	18.2
Numerator	545	525	532	597	606
Denominator	31176	31340	31738	33264	33264
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	17.8	17.7	17.6	17.5	17.4

Notes - 2007
Population not available until July 2008. Used population estimate from 2006 as estimated denominator

Notes - 2006
Population not available until July 2007. Used population estimate from 2005 as estimated denominator

Notes - 2005
Data will be available September 2006.

a. Last Year's Accomplishments
During CY 2007, family planning clinics around the state served a total of 3,135 teens aged 15-17 years compared with 3,465 teens aged 15-17 years who received services in CY 2006. That is a decrease of 10.5 percent, or 330 clients, who were served in CY 2007. Idaho's 2007 teen pregnancy rate for 15-17 year olds is 18.2 percent (provisional data). The 2006 teen pregnancy rate was 17.9 percent. The data show a slight decrease in the teen pregnancy rates for 2004 and 2005 and a slight increase in the rates for 2006 and 2007.

These clients all received physical assessment, education and counseling services. All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STI/STD prevention.

On September 10, Ella Gordon, FNP, joined the Sexual and Reproductive Health Program as the Family Planning Nurse Coordinator.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to teens through the public health districts.	X		X	
2. Develop comprehensive educational messages targeted to teens.		X	X	X
3. Continue to conduct Teen Education Afternoon (TEA) local district clinic project.		X	X	
4. Continue program collaboration and coordination activities with the Adolescent Pregnancy Prevention Program.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In January, the Sexual and Reproductive Health Program was renamed to the Family Planning, STD, and HIV Programs. Staff believes the new name is more descriptive of the services provided by the program.

The Adolescent Pregnancy Prevention (APP) manager has worked to rebuild the program and is currently developing a media campaign focused on reducing adolescent pregnancy rates. The campaign will include information about relationship safety and dating etiquette. The APP Manager, the Family Planning Coordinator, and the STD Prevention Coordinator meet together monthly to discuss collaboration and coordination efforts between their programs.

All of the local health districts have active advisory boards within their family planning programs which guide the content of education materials and provide direction for outreach activities. All of the advisory boards have committee members of various backgrounds including faith based members and teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups.

All health districts provide family planning services to teen clients. Many districts provide extended clinic hours in the evening to accommodate teen client's schedules.

c. Plan for the Coming Year

Program collaboration, coordination, and integration activities will expand as program coordinators from the Family Planning, STD, and HIV Programs (FPSHP) continue to conduct integrated on-site program reviews of their respective programs at health districts. Technical assistance will focus on providing ideas on how to streamline and integrate program service delivery activities across all the programs within the FPSHP.

Comprehensive educational messages will continue to be developed that target teens and provide information on issues like abstinence, STIs, parental involvement, sexual coercion, and birth control methods.

The Teen Education Afternoon (TEA) clinic will continue to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling and up-to-date information on hot topics occurring within the health district. Client-centered, one-on-one counseling is also provided.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	62	64	66	60
Annual Indicator	49.9	50.1	55.7	55.7	55.7
Numerator	9426	370	10315		
Denominator	18890	739	18527		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60.5	60.6	60.7	60.8	60.9

Notes - 2007
SMILES survey used to estimate not conducted in 2007. 2005 rate used as latest available estimate.

Notes - 2006
SMILES survey used to estimate not conducted in 2006. 2005 rate used as estimate.

Notes - 2005
Data Source 2005 Smile Survey

a. Last Year's Accomplishments
Contracts with the seven district health departments continue to provide dental sealants, flouride varnish and, in some areas of the state, the fluoride mouth rinse program. The Idaho Oral Health Alliance gained autonomy as a 501(c)3. The transition to a non-profit status and the retirement of the state Oral Health Program manager after 37 years, made this very much a transitional year. For the majority of the year, the program had either no program manager or a part-time program manager. Major accomplishments were the development of a draft State Oral Health Plan and a cost analysis of how the program is currently delivered.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V support for district oral health programs will be maintained at the current level.			X	
2.				

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program is in a position to just maintain current activities. The program manager position is again vacant. Following the last round of interviews, an offer was made to a very qualified candidate but, the candidate declined the position. At this time no additional or new activities will be added to the program.

The Smiles Survey was not conducted this year. Children's dental needs were addressed through contracts with the seven health districts. Through these contracted services 300 Idaho school children received fluoride varnish and 614 received sealants.

c. Plan for the Coming Year

We will maintain current activities while the scope of the program as well as placement within the organization is analyzed. The Oral Health Program will remain in the Bureau of Community and Environmental Health. The program will be managed by the Diabetes Program manager.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	5	4.5	4	4	4
Annual Indicator	6.8	5.5	5.8	4.0	6.8
Numerator	21	17	18	13	22
Denominator	307803	308270	308945	325906	325906
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5

Notes - 2007

Death count preliminary total from ISP for 2007
Population count for 2007 not available until July 2008, 2006 population estimate used as estimate.

Notes - 2006

Death count preliminary total from ISP for 2006
Population count for 2006 not available until July 2006, 2005 population estimate used as estimate.

Notes - 2005
2005 data not available until September 2006.

a. Last Year's Accomplishments
The Injury Prevention Program has narrowed its focus and solely addresses fall prevention among those 65 and older.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Although the Injury Prevention Program will continue to monitor mortality rates for those 14 years and younger caused by motor vehicle crashes, it will shift focus to falls among the elderly.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The child safety seat program is administered through partners at the local level.

c. Plan for the Coming Year
We will continue to monitor the rate of death to children 14 years of age and younger due to motor vehicle crashes. IDHW will continue to support relevant legislation. During the coming year, we will be looking at developing an injury prevention program that addresses MCH concerns.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				50	51
Annual Indicator			49.8	50.5	54
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	51.5	52	52.5	53	53.5

Notes - 2007
Data source is 2006 Idaho PRATS survey. Data for 2007 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would the results of weighted survey sample data.

Notes - 2005
2005 CDC National Immunizatoin Survey data only shows rate. Numerator and Denominator not available.

Data Source:
http://www.cdc.gov/breastfeeding/data/NIS_data/data_2005.htm

a. Last Year's Accomplishments
1) In FY08, the State Office supported efforts of Local Breastfeeding Coalitions to provide trainings for healthcare professionals and community members who work with populations that would benefit from breastfeeding education to meet specific needs for their area.

2) The State Office continued to provide Healthy Perks for Moms who Work Toolkits to area Breastfeeding Coalitions so that they may continue to train area employers.

3) The State Breastfeeding Workgroup developed and implemented educational materials on common concerns that affect duration of breastfeeding. The topic cards are on milk supply, sore nipples, thrush, mastitis, and relactation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Designate employers as Breastfeeding Friendly.			X	
2. Provide Breastfeeding Best Practice grants for higher level staff training and World Breastfeeding Week community activities.		X		X
3. Provide breastfeeding topic cards to breastfeeding educators around the state to assist with common concerns that may effect breastfeeding duration.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

1) Employers around the state are receiving the designation of Breastfeeding Friendly including hospitals, health departments, and businesses.

2) The State WIC Program continues to provide Local WIC Agencies with Best Practice Grants to achieve higher standards in breastfeeding education and support. Part of the grant requires implementation of World Breastfeeding Week activities.

c. Plan for the Coming Year

1) In FY09, the State Office will continue to support efforts of Local Breastfeeding Coalitions in providing trainings that attract healthcare professionals and community members who work with populations that would benefit from breastfeeding education that meet specific needs in their area.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	93.9	94.2	94.6	98.4	96.7
Numerator				22302	
Denominator				22657	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98.8	98.9	99	99.1	99.2

Notes - 2007

Data source is 2006 Idaho PRATS survey. Data for 2007 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006

Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses indicating that the baby was tested after hospital discharge or that the baby was not born at a hospital but was tested were not included in the denominator.

Notes - 2005
Data Source: Vital Statistics

a. Last Year's Accomplishments
During CY 2007, 27 infants were identified with sensorineural hearing loss; one of these infants was identified with a mixed hearing loss (both permanent sensorineural loss and conductive loss), and 5 infants were identified with fluctuating conductive loss. The Idaho Early Hearing Detection and Intervention (EHDI) program applied for and was granted another three years of federal funding for reducing loss to follow-up after failure to pass newborn hearing screening. The EHDI program was integrated into the Idaho Infant Toddler Program (Part C).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V support for the Newborn Hearing Program will be maintained at the current level.			X	X
2. Match or exceed the national benchmarks set by JCIH.			X	
3. Increase family to family support and access to information to assist families.		X		
4. Expand newborn hearing screening to other community-based sites, e.g. district health departments.			X	X
5. Increase and improve the participation of physicians in EHDI and in the provision of a medical home.				X
6. Participate in Early Years Conference to educate early interventionists and other service providers involved in Idaho's EHDI Program.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The EHDI program continues to work with its partners, including birth hospitals, audiologists, early intervention, the AAP, and others to ensure that babies who do not pass the two stage screening are referred promptly for and receive diagnostic testing. Educational and outreach activities focus on the screening sites, testing sites, and the medical home, and include disseminating newborn hearing screening information prenatally to expectant parents through obstetrician offices. The program is also piloting the use of portable ABR screening equipment for several rural areas.

c. Plan for the Coming Year
The Title V agency will renew the memorandum of understanding with the Idaho Infant Toddler Program (Part C) to provide services related to newborn hearing screening.. The Idaho EHDI program will be in its ninth year of funding and will further strengthen its connections with the Part C program, including joint education and training with Part C outreach personnel in hearing screening and interventions. A survey of audiologists will be undertaken and subsequent training provided to ensure that pediatric audiologic services are available in all areas of the state. The program, with its partners, will work towards integrating the new 2007 JCIH guidelines for hearing screening and follow-up and continue to work towards the goal of 75% of hospitals achieving the

benchmarks on at least 3 of the 4 performance measures. The program also plans to implement procedures to begin to capture data on many of the out of hospital births.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	12	12	12	12	11.2
Annual Indicator	13	13	13.0	11.4	13.0
Numerator			19177	44995	52135
Denominator			147366	394435	401854
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.5	12.4	12.3	12.3	12.3

Notes - 2007
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2007

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Notes - 2006
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2006

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Notes - 2005
Data Source: Census.gov

a. Last Year's Accomplishments
Idaho was one of the first states to take advantage of the DRA option for benchmark benefit packages under the state plan. The effort to convert the Medicaid and SCHIP programs was known as Idaho Medicaid Modernization. Also, a new governor was elected in November 2006. This was Idaho's third governor in eight months. Against this backdrop, the provisions of Idaho's Medicaid Modernization plan were implemented. The emphasis was shifted to promote prevention, health, and wellness.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement expanded CHIP coverage through child-only health care only applications.				X
2. Work toward gaining expanded Medicaid coverage for young women of reproductive age.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Idaho Medicaid developed a plan to begin targeting efforts to reach those children already eligible for either SCHIP or Medicaid, but who are not enrolled. The Legislature's Health Care Task Force began a series of meetings in July focused on access to and cost of care in the state.

In August, Governor Otter convened a Health Care Summit and appointed a Select Committee to address health care issues in Idaho. The committee report can be accessed at: http://gov.idaho.gov/healthcarerecommendations.pdf.

All year, SCHIP reauthorization efforts were garnering national attention. Idaho has been fiscally prudent with its federal allotments and is not at risk of experiencing a short fall during negotiations. The state's economy also improved during the reporting period. All these factors have provided a viable environment in promoting child health issues in Idaho during the reporting period.

Accomplishments:

A new benefit, Wellness Preventive Health Assistance (PHA), was instituted as a disenrollment protection. By keeping a child's well-child exams and immunizations current, the family can have the equivalent of $30 per quarter applied as an offset to required premiums. This is intended to reduce the number of children terminated from SCHIP coverage for failure to pay premiums and to promote prevention and wellness.

A new brochure was developed.

Enrollment into Healthy Connections was expedited without compromise to enrolle selection of provider.

c. Plan for the Coming Year

We are working on a child-only health care-only application and several other strategies involving electronic applications (such as interface directly with hospitals) and will explore Express Lane strategies with Free and Reduced Lunch and the WIC programs. To reduce churn, processes for administrative renewals will be explored. These activities are intended to help us attain our goal of enrolling all children who are eligible for our programs but who are not enrolled.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				26	31
Annual Indicator			28.9	32.1	31.2
Numerator			5240	5807	5894
Denominator			18137	18113	18862
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	31	30.9	30.8	30.7	30.6

Notes - 2007
Based on PedNSS data avail as of 1/17/2008

Notes - 2006
Based on PedNSS data avail as of 1/16/2007

Changes in unit conversion measures and BMI comparison data from 2005 reduce comparability with previous data. Using method for 2006 data values for previous years would be:

2002 29.0 percent
2003 28.2 percent
2004 29.4 percent
2005 31.3 percent

a. Last Year's Accomplishments
The Fit Kids Project evaluation and performance measures were shared with partners.

WIC Participated in the Idaho Hunger Taskforce. A statewide Hunger Summit will be held in October 2008.

WIC and the Idaho Physical Activity and Nutrition Program partnered on a healthy lifestyle calendar that provides ideas for incorporating healthy food and activity choices. The calendar was used for education and program outreach.
35,000 calendars were printed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Share performance measure with Local Agency WIC Coordinators, the Idaho Association of Pediatrics, and the Idaho				X

Physical Activity and Nutrition Program.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Discussion for project ideas with the Idaho Physical Activity and Nutrition Program continues on an ongoing basis.

c. Plan for the Coming Year
Will continue discussion for project ideas with the Idaho Physical Activity and Nutrition Program. Plans are underway to print a 2009 Calendar.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				8	8
Annual Indicator				9.4	9.0
Numerator				2258	2230
Denominator				24112	24651
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8.5	8.5	8.4	8.4	8.3

Notes - 2007
Out of state birth certificates do not necessarily include smoking during pregnancy. Denominator reflects those that do record smoking status.

Notes - 2006
Out of state birth certificates do not necessarily include smoking during pregnancy. Denominator reflects those that do record smoking status.

Notes - 2005
2005 data available in September 2006.

Data Source: Vital Statistics

a. Last Year's Accomplishments
Completed the KISS project with approximately 300 pregnant and/or new moms in Health Districts 1, 2, and 3. Mothers were provided with smoking cessation materials and educational packets on the harmful effects of tobacco smoke.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Alcohol, tobacco, and other drugs initiative			X	X
2. Provide family planning services to educate pregnant women on the risk of tobacco use.	X		X	
3. Provide WIC services to pregnant women.			X	
4. Continue tobacco cessation classes at local health districts.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Project Filter is currently conducting follow-up surveys with a random sampling of mothers who participated in the KISS campaign. Surveys will measure the belief of mothers in the harmful effects of tobacco smoke on the newborns, exposure of the newborn to tobacco smoke at home and in the vehicle, cessation efforts made by the mother or other smokers in the home and finally quit rate over time (were mothers who quit smoking during pregnancy able to stay smoke-free).

c. Plan for the Coming Year
Project Filter will finish follow-up surveys with mothers who participated in the program and make programmatic decisions based on the survey results. Project Filter will be offering free Nicotine Replacement Therapies (NRT's) through QuitNet and QuitLine, cessations programs, beginning on July 1, 2008 for all Idaho residents.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	19	13	12	11	8.5

Annual Indicator	13.8	13.8	9.1	11.7	11.7
Numerator	15	15	10	13	13
Denominator	108796	108840	109731	110742	110742
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11	10.9	10.9	10.8	10.8

Notes - 2007
2007 death records have not been finalized, 2006 deaths have been used as best estimate.
2007 population by age not available at time of entry, 2006 used as best estimate.

Notes - 2006
Not all death records for 2006 have been received.
2005 population data is used as estimate for 2006.

Notes - 2005
2005 data not available until September 2006.

a. Last Year's Accomplishments
Idaho State University Institute of Rural Health conducted Better Todays. Better Tomorrows. under a grant from the Idaho Department of Health and Welfare and partnered with ISU Youth Suicide Prevention Project under a grant from the Substance Abuse and Mental Health Services Administration. 1,500 adult gatekeepers were trained statewide on children/youth suicide risk and protective factors, resilience and asset-building, bringing the total number trained since 2000 to about 7,000. Twenty-two Idaho volunteers from all regions were trained to conduct gatekeeper trainings using the established Better Todays ISU curriculum. A suicide prevention toolkit for awareness activities was designed and distributed. Radio advertisements were created both for youth and parent/grandparent target audiences. A guide for awareness activities was created for Asian and Pacific Islanders, Hispanics and Alaska Natives and American Indians. Tabletop displays at a variety of public health conferences were conducted. A 35-member advisory group for YSP was trained in Social Marketing and Strategic Planning to boost local sustainability efforts. ISU-IRH contracted with the Suicide Prevention Action Network of Idaho to do clergy trainings. Eight videoconference educational sessions were offered. A contract with the Idaho Federation of Families for Children's Mental Health focused on youth-led awareness activities in schools. ISU designed and tested an interactive curriculum for resident assistants. Spanish radio novellas were created and distributed and the Better Todays/YSP curriculum and materials were translated into Spanish. The Idaho Council on Suicide Prevention went through a transformation and has been moved from the Governor's Office to a subcommittee of the State Planning Council on Mental Health. Better Todays and YSP Project Director Ann Kirkwood serves on the new suicide prevention subcommittee of the mental health planning council. Several Idaho communities report suicide clusters in the past year and ISU-IRH will be responding to their requests for educational programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue Youth Suicide Prevention Early Intervention				X

Coalition, a State-level public/private partnership.				
2. Provide gatekeeper training for university residence hall staff, other student staff, and other community gatekeepers.				X
3. Continuation of promoting evidence-informed practices.				X
4. Statewide suicide prevention referral sources will be available through 2-1-1 Idaho CareLine.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

ISU-IRH's Better Todays and YSP is partnering with the Idaho Federation of Families for Children's Mental Health to offer parent trainings statewide in the summer of 2008. The ISU Counseling Center is completing a curriculum guide for its resident assistant program which will be distributed to colleges and universities statewide. Data analysis is under way reflecting outcomes of the 2007-2008 training year. Advisory group members are preparing sustainability plans for local suicide prevention and to guide YSP activities in the final year of the grant. Local SPAN chapters are conducting awareness activities identified in the toolkits, including radio ads, media interviews, public forums and events. In addition to promoting TeenScreen, ISU is providing information on an array of other evidence-informed suicide prevention activities to local stakeholders. ISU is working with tribes to offer culturally appropriate suicide prevention activities on Idaho's reservations, as well as working with university-based cultural centers and campus media. ISU-IRH is working with communities that have experienced suicide contagion for appropriate postvention and education activities, as identified by the national Suicide Prevention Resource Center.

c. Plan for the Coming Year

ISU-IRH will conduct videoconference trainings over 4 weeks in October 2008 and May 2009. In-Person trainings also are scheduled for the faculty and staff at the College of Southern Idaho and Jerome, Idaho, school district in the fall. ISU will fund individuals statewide to become QPR trainers. Kirkwood will visit trainings and trainers who are offering the Better Todays/YSP curriculum will be monitored for fidelity of content and trainee satisfaction. A data subcommittee has identified gaps in Idaho data regarding suicide and possible sources for filling some of those gaps. The subcommittee will create a document for future use in identifying and assessing Idaho data on suicide. Information on suicide prevention and postvention resources will be entered into the state information and referral database. Uncertainties over state funding for Better Todays may impact the breadth of training activities post October 1, 2008. The YSP grant expires in May 2009.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	66	75	75	75	75
Annual Indicator	72.8	99	99	99	99
Numerator	142				
Denominator	195				

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75	75	75	75	75

Notes - 2007
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

Notes - 2006
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

Notes - 2005
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure.

a. Last Year's Accomplishments
The primary project addressing this performance measure is the lay-midwive project. This project is aimed at improving the general knowledge of lay-midwives regarding services available, important medical screenings and important medical benchmarks. The Idaho Perinatal Project (IPP) holds the contract for these activities. The Mother's Journals have been very well received by both mothers and caregivers.

The lending library continues to expand with the addtion of DVDs and books. The lending library also added an "empathy belly." This educational tool can be used in childbirth classes, high school and college classes and hospital staff education to stimulate pregnancy and used to start an engaging and interactive educational program, and we expect it to be widely used by health care providers statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2. The Family Planning Program will provide pregnancy tests and make referrals as appropriate.	X		X	
3. Continue Lay-midwife project with Idaho Perinatal Project.			X	X
4. Continue implementation of Oral Health for Pregnant Women project.			X	X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
IPP is entering its 4th year with the lay midwife porject. Educational and outreach activities continue to be developed and distributed.

HB 488 was before the legislature during the 2008 session. This bill would have allowed for the voluntary licensure of lay midwives. The IPP was very active in testifying against this bill. The bill was pulled back to the House Health and Welfare Committee essentially killing it for this session.

The IPP Winter Conference was held February 21-22, 2008.

c. Plan for the Coming Year
Funding will be provided for at least one more year for the lay midwife project. The IPP Advisory Board is already considering legislative approaches and strategies for the 2009 session as the issue of voluntary licensure will again be before lawmakers.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	83	84	85	86	78
Annual Indicator	81.3	71.9	71.4	71.7	71.7
Numerator	17091	15455	15889	16772	17396
Denominator	21012	21502	22245	23391	24251
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	73	73.2	73.4	73.6	73.8

Notes - 2007
2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

Notes - 2006
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

Notes - 2005
In 2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record.

a. Last Year's Accomplishments
During CY 2007, 27,467 women received counseling from the family planning program. Of those women, 2,551 were found to be pregnant. Those women who were pregnant were screened for high risk behaviors and referrals were made as indicated. All women were referred appropriately to obstetricians in order to begin early prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Planning Program will provide pregnancy testing and referral for prenatal care.	X		X	
2. Utilize PRATS.				X
3. The WIC Program will provide nutritional counseling and information on other pregnancy risk factors.			X	
4. The Idaho CareLine will provide referrals for prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Women continue to receive program services including counseling from the family planning program. Women found to be pregnant are screened for high risk behaviors and appropriate referrals are made. Pregnant women continue to be appropriately referred to obstetricians in order to begin early prenatal care.

c. Plan for the Coming Year
Women will receive program services including counseling from the family planning program. Women found to be pregnant will be screened for high risk behaviors and appropriate referrals will be made. Pregnant women will be appropriately referred to obstetricians in order to begin early prenatal care.

D. State Performance Measures

State Performance Measure 1: *Percent of mothers who were screened for post partum depression within one month following delivery.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective				75	75
Annual Indicator		99	99	99	99
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	80	80	80	80	80

Notes - 2007
No screening data is available at this time. 99 has been entered to save form.

From the 2006 Idaho PRATS survey 55.4% of women self-report they were "a little depressed," "moderately depressed," or "very depressed" during the 3 months following delivery. This is not entered on the form as it is not the result of any form of clinical screening and the time period does not match that of the measure.

PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
No screening data is available at this time. Questions for the PRATS survey are being developed to capture this data. 99 has been entered to save form.

Notes - 2005
No screening data is available at this time. Questions for the PRATS survey are being developed to capture this data.

a. Last Year's Accomplishments
Local health districts have a desire to address PPD in their offices in the way of increased screening, however, the system will continue to lack the infrastructure for referral until something changes. In 2006, a new Division within the Department of Health and Welfare was established. This new Behavioral Health Division will be approached to partner with current stakeholders to begin addressing systems building and provide support for such a program.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Complete needs assessment to identify use of screening tools.				X
2. Develop project centered on post-partum depression to identify and address barriers facing women with post-partum depression.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Because PPD in Idaho is a high priority, partners throughout the state continue to look for ways to improve the system.

c. Plan for the Coming Year
Post-partum depression continues to be of concern to Idaho, however the infrastructure to effectively refer women following screening is still an issue. Collaboration between stakeholders such as the Idaho Perinatal Project, the Early Childhood Coordinating Council, the Department of Health and Welfare, hospitals, etc. continues.

State Performance Measure 2: *The percent of Medicaid and SCHIP children ages 1 and 2 that received the expected number of EPSDT screens.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				75	75.2
Annual Indicator			70.5	67.4	66.4
Numerator			16834	16430	17301
Denominator			23865	24390	26045
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75.4	75.6	75.8	76	76

Notes - 2007
Values entered reflect EPSDT screenings for Medicaid and Idaho CHIP enrollees <=1 year of age only.

Form 17 HSC 02 and 03 combined.

Notes - 2006
Values entered reflect EPSDT screenings for Medicaid and Idaho CHIP enrollees <=1 year of age only.

Form 17 HSC 02 and 03 combined.

Notes - 2005
Entered values match Form 17 HSC 02, which reflects medicaid only and less than 1 year of age.

a. Last Year's Accomplishments
The annual report of the State Children's Health Insurance Plans revealed a dramatic change in the percent of children receiving EPSDT screens. As previously noted, it was suspected that the state's very low percentage of 'children 0-24 months with the number of well child checks expected' (32%) was related to a flaw in Medicaid's database. The system underwent reprogramming and the EPSDT rate for 2006 was reported at 95%. The system will continue to be evaluated for validity each year to determine the accuracy of the data being reported.

As part of Medicaid Modernization implemented in July 0f 2006, the reimbursement rate to PCP's for well child exams was increased to match commercial rates. At this time the participant handbook was also updated. The first benefit highlighted in the Basic Plan is "Prevention" and encourages parents to take their children to their PCP for well child exams. For SCHIP children (those that have to pay premiums), a Preventive Health Assistance (PHA) benefit was instituted. Under this benefit, parents can earn points that can be used to offset any delinquent premiums by keeping their children's well child exams and immunizations up-to-date.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase in reimbursment for well child (EPSDT) screenings.				X
2. Education of providers and parents regarding changes to Medicaid modernization.		X		
3. Continue referrals as necessary for children who do not have a regular health care provider.		X		
4. Reminder letters sent to all children enrolled in Medicaid.		X		
5. Enhance preventive services targeted to young children and families through Medicaid.	X			X
6. Continue monitoring Medicaid data to evaluate number of children receiving appropriate screens.				X
7.				
8.				
9.				
10.				

b. Current Activities

Medicaid has put more effort into educating providers this year with changes related to Medicaid Modernization. One area that has specifically been addressed is related to a misunderstanding of Medicaid's schedule for well child exams. Idaho has always followed the American Academy of Pediatrics periodicity chart. However, the provider handbook had not been updated for several years to reflect any changes to this chart. An updated version of the provider handbook was published in May of 2007 and reflects an additional number of recommended examinations.

During the spring, training was developed and presented statewide to a mixed audience of Family and Community Services regional staff, providers and advocates. The importance of well child exams was emphasized as the starting point for any extended benefits a child might need. This same presentation was given at the Systems of Care Conference on EPSDT.

Data continues to be monitored to assure that there is not an immunization disparity in the Medicaid population as compared to the general population. Data for this current year suggest that all immunization rates went down, but that Medicaid children and non-Medicaid children are equally immunized.

c. Plan for the Coming Year

Education of parents and providers with regard for the importance of well child checks will continue to be a high priority given the focus of prevention with Medicaid Modernization.

State Performance Measure 3: *Percent of 9th - 12th grade students that report having engaged in sexual intercourse.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					36.5
Annual Indicator		38.5	39	39	42
Numerator					
Denominator					

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36	35.5	35	34.5	34.5

Notes - 2007
YRBS Survey in 2007
Results from: RESULTS OF THE 2007 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2006 SCHOOL HEALTH EDUCATION PROFILE, November 2007
Numerator and denominator not available

Notes - 2006
YRBS Survey not conducted in 2006
Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006
used as estimate for 2006
Numerator and denominator not available

Notes - 2005
2005 YRBS Survey Data available in June 2006.
Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006

Numerator and denominator not available

a. Last Year's Accomplishments
During CY 2007, family planning clinics around the state served a total of 3,135 teens aged 15-17 years compared with 3,465 teens aged 15-17 years who received services in CY 2006. That is a decrease of 10.5 percent, or 330 clients, who were served in CY 2007. Idaho's 2007 teen pregnancy rate for 15-17 year olds is 18.2 percent (provisional data). The 2006 teen pregnancy rate was 17.9 percent. The data show a slight decrease in the teen pregnancy rates for 2004 and 2005 and a slight increase in the rates for 2006 and 2007.

These clients all received physical assessment, education and counseling services. All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, contraception and STI/STD prevention.

On September 10, Ella Gordon, FNP, joined the Sexual and Reproductive Health Program as the Family Planning Nurse Coordinator.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support local health district advisory boards, which guide education materials and outreach.		X	X	
2. Ada County Juvenile Detection Center project.			X	
3. Reproductive health information through high school classes.		X		
4. Continue to develop comprehensive educational methods targeted to teens.		X		X
5. Teen Education Afternoon (TEA) health district clinic.		X	X	
6.				
7.				
8.				
9.				

10.				

b. Current Activities
In January, the Sexual and Reproductive Health Program was renamed to the Family Planning, STD, and HIV Programs. Staff believes the new name is more descriptive of the services provided by the program.

All of the local health districts have active advisory boards within their family planning programs which guide the content of education materials and provide direction for outreach activities. All of the advisory boards have committee members of various backgrounds including faith based members and teen representation. These relationships have allowed the boards to develop more trusting relationships with local groups.

All health districts provide family planning services to teen clients. Many districts provide extended clinic hours in the evening to accommodate teen client's schedules.

The Teen Education Afternoon (TEA) clinic continues to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling and up-to-date information on hot topics occurring within the health district. Client-centered, one-on-one counseling is also provided.

c. Plan for the Coming Year
Comprehensive educational messages will continue to be developed that target teens and provide information on issues like abstinence, STIs, parental involvement, sexual coercion, and birth control methods.

The Teen Education Afternoon (TEA) clinic will continue to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling and up-to-date information on hot topics occurring within the health district. Client-centered, one-on-one counseling is also provided.

The Ada County Juvenile Detention Center project will continue during FY 2009. The project provides access to reproductive health care services for high-risk adolescents. Residents will be given the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations will be given to measure the level of intention to the change of risky sexual behaviors.

The Teen Education Afternoon (TEA) clinic will continue to be available to teens 13-19 years of age. TEA is a walk-in clinic service for teens that is conducted every Thursday afternoon. During the clinic, teens are screened for STIs as related to their risk behaviors and a risk reduction plan is developed. Information is offered on how to say no to sexual pressure, immunizations, pregnancy education, testing and counseling and up-to-date information on hot topics occurring within the health district. Client-centered, one-on-one counseling is also provided.

State Performance Measure 4: *Percent of 9th – 12th grade students who used any type of tobacco in the past 30 days*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	0
Annual Indicator	17.8	17.8	21.4	21.4	26.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0	0	0	0	0

Notes - 2007
Based on 2007 YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

Goals are 0 because someone in the past entered a zero and we are not allowed to enter any value larger

Notes - 2006
YRBS not conducted in 2006, 2005 results used as estimate for 2006.
Based on YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

Goals are 0 because someone in the past entered a zero and we are not allowed to enter any value larger

Notes - 2005
2005 YRBS data available in June 2006.
Based on YRBS questions regarding cigarette smoking and smokeless tobacco use.

Numerator and denominator not available

a. Last Year's Accomplishments
Project Filter continued to support the American Lung Association of Idaho in implementation of the Teens Against Tobacco use (TATU) program in Idaho schools. Project Filter supports the American Lung Association's efforts to implement TATU through our contract with local Health Districts. The TATU program trained approximately 400 high school students as peer educators who saw over 8,600 elementary and junior high school students. Students are also reached through on campus marketing efforts and school announcements. Peer Educators are trained in the TATU tobacco prevention curriculum and receive training on presentation skills.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate and implement TATU program in 5 of 7 health districts.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Project Filter supported 5 of 7 Health Districts in working in collaboration with the American Lung Association in the implementation and coordination of their TATU program in rural high schools in Idaho. No other activities are planned for this year.

c. Plan for the Coming Year
Project Filter will once again be working with the American Lung Association of Idaho and the local Health Districts to further coordinate and implement TATU in Idaho schools. Program focus will continue to be on underserved rural schools in Idaho while maintaining TATU groups at existing schools.

State Performance Measure 5: *Percent of pregnant women who received dental care during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				50	45
Annual Indicator		39.3	43.6	43.6	43.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45.1	45.3	45.5	45.7	45.9

Notes - 2007
Data source is 2006 Idaho PRATS survey. Data for 2007 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data.

Notes - 2006
Data source is 2005 Idaho PRATS survey. Data for 2006 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses with unknown data were not included in the denominator.

Notes - 2005
Data source is 2005 Idaho PRATS survey. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would the results of weighted survey sample data.

Responses with unknown data were not included in the denominator.

a. Last Year's Accomplishments
Contracts with the health districts were discontinued for this activity. While the program was initially well received and there was a ground swell of interest, finding dental providers to see Medicaid women during their pregnancy proved to be insurmontable

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish referral network for physicians and dentists.				X
2. Conduct survey of dentists regarding acceptance of Medicaid referred patients.			X	X
3. Continue evaluation of PRATS and Idaho Birth Certificate data.				X
4. Continue to improve dental coverage for pregnant women through Medicaid.				X
5. Educate providers and pregnant women regarding link between good oral health and improved birth outcomes.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Printed educational materials are still available and were distributed at the Idaho Perinatal Conference as well as to any one requesting the information. There in no ongoing activity with this program.

c. Plan for the Coming Year
The distribution of printed educational material will continue. PRATS survey data is still being collected. The planning committee for the Early Years Conference to be held in November 2008 is considering having a speaker to address the importance of dental care during pregnancy. These activities will continue to keep the awareness level of this performance measure up.

State Performance Measure 6: *Percent of Medicaid and SCHIP children who are fully immunized by age 2.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				90	90
Annual Indicator			80	65	63
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
The rate is calculated from provider assessments.

Notes - 2006
#SP6 Notes – 2005
Data is an estimate from IRIS data.

Notes – 2006
Data is an estimate from provider visit assessments

Notes - 2005
Data is an estimate from IRIS data.

a. Last Year's Accomplishments
Beginning in 2006, the Idaho Immunization Program (IIP) modified the information collected in physician's offices during a scheduled quality assurance visit to include the Medicaid status of each patient assessed. The IIP continued to collect and assess this information in 2007.

There is a significant difference between Medicaid and non-Medicaid children with rates of 70% and 63% respectively for the 4:3:1:3:3 (4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B) series.

The IIP also partnered with Medicaid to monitor, develop, and implement strategies to increase immunization rates.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing evaluation of the Medicaid population's immunization rate through chart review.				X
2. Ongoing evaluation of the state immunization rate for all children.				X
3. Referral for immunization through WIC link linkage.				X
4. Educate public regarding immunization awareness.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The IIP is continuing to monitor the data collected from the Quality Assurance Reviews. The IIP has established protocols, which include collecting the Medicaid status of each patient assessed. This data is entered into Co-CASA and analyzed.

The IIP has developed a strategic plan for improving immunization coverage levels. As part of the strategic plan, the IIP has re-developed the Quality Assurance program so that it targets immunization providers that do not have a minimum of 80% coverage level for the 4:3:1:3:3:1 (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella) immunization series. Providers that do not have at least an 80% coverage rate will receive an action plan developed by the Quality Assurance Specialist (QAS) in conjunction with the provider. The Quality Assurance Specialists are communicating the importance of all children receiving immunizations and bringing special attention to missed opportunities. The IIP will be rolling out an aggressive media campaign aimed at increasing immunization rates beginning in late 2008. The IIP plans to visit approximately two-thirds of all VFC providers in 2008 with Quality Assurance Reviews.

c. Plan for the Coming Year

The IIP will continue to partner with Medicaid to monitor and implement strategies to increase immunization rates as a result of the difference in coverage levels between non-Medicaid and Medicaid children.

The IIP will also continue to implement the strategic plan developed in late 2007 to increase immunization rates for both Medicaid and non-Medicaid children.

State Performance Measure 7: *Percent of 9th – 12th grade students that are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				0	0
Annual Indicator	7.4	7.2	7	7	11
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0	0	0	0	0

Notes - 2007
YRBS Survey in 2007
Results from: RESULTS OF THE 2007 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2006 SCHOOL HEALTH EDUCATION PROFILE, November 2007
Numerator and denominator not available

Objective rates are set at 0 because of an error at some time in the past an we are unable to adjust to more realistic objectives due to entry constraints imposed by the entry form.

Notes - 2006
YRBS not conducted in 2006
Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006
used as estimate for 2006
Numerator and denominator not available

Notes - 2005
2005 YRBS survey data available in June 2006.
Results from: RESULTS OF THE 2005 IDAHO YOUTH RISK BEHAVIOR SURVEY AND 2004 SCHOOL HEALTH EDUCATION PROFILE, April 2006

Numerator and denominator not available

a. Last Year's Accomplishments
An organizational meeting of the state Physical Activity and Nutrition Alliance was held in May 2007 and further organizational efforts are ongoing.

A "Healthy Habits, Healthy Families" Handbook with similar content to the calendar was developed and printed.

A surveillance project to determine the prevalence of overweight elementary-aged children in Idaho was designed and approved through IDHW's Institutional Review Board (IRB).

Two 30-second television commercials were aired and the call to action was to contact the Idaho

2-1-1 CareLine for a free "Healthy Habits, Healthy Families" calendar.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop media campaign to encourage families to become more active and eat better using Idaho CareLine.		X		
2. Technical assistance will be made available to schools regarding their school wellness policies.				X
3. Formalize a state Physical Activity and Nutrition Alliance/Coalition.				X
4. Conduct BMI surveillance of 3rd graders.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

"Healthy Habits, Healthy Families" Handbook with similar content to the calendar was distributed to local health districts, the Idaho 2-1-1 CareLine, and other partners.

Translate and printed PAN core message brochure in Spanish. Brochure distributed to local health districts, the Idaho 2-1-1 CareLine and other partners.

The state PAN program and PAN coordinators from the health districts attended an Action for Healthy Kids statewide kickoff meeting in April 2008.

The health districts conducted BMI surveillance of Idaho third graders and submitted data to IDHW. IDHW will analyze data and prepare reports.

Follow-up with recipients of 2007 and 2008 calendars through a phone survey to evaluate effectiveness of the calendar.

Provide core message tabletop displays to each health district and provided technical assistance as needed.

Hire Coordinated School Health Program Specialist to work jointly with the State Department of Education's Physical Activity, Nutrition and Tobacco-use Prevention Specialist (PANT Coordinator). Idaho received Coordinated School Health funding in March 2008.

c. Plan for the Coming Year

Translation of the "Healthy Habits, Healthy Families" Handbook into Spanish for distribution through the Idaho 2-1-1 CareLine and the health districts.

Develop local Action for Healthy Kids committees within each health district.

E. Health Status Indicators

The health status indicators provide quite comprehensive demographic information as well as select birth, death and condition information. While all of this information is available elsewhere, it consolidates key measures of significance to the MCH population and program in one area.

This data allows us a comprehensive picture of who current funding is affecting either directly or indirectly. Through the evaluation of outcomes from each of these programs or areas, we are able to weigh the impact of our funding and shift funds as necessary in order to serve the most individuals at highest risk. While this state level data points may assist in program direction, Idaho efforts such as the expanded PRATS survey make it possible for us to look at the issues at a more local level.

Surveillance of these key indicators allows us to monitor our progress in relationship to other MCH programs. The indicators are not particularly useful for evaluation purposes.

F. Other Program Activities

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis, evaluation and management.

The CSHP Program will continue to provide biannual regional PKU clinics in Boise, Idaho Falls, and Spokane, Washington. Idaho has made the decision to consolidate PKU services under one physician in effort to provide consistent care from birth through 18. Dr. Ron Scott will discontinue staffing Idaho clinics during the summer of 2005 and Dr. Cary Harding from Oregon Health and Science University will be taking his place. Families receive initial consultation from OHSU and Dr. Harding already comes to Idaho to see children with other metabolic disorders.

/2008/ The CSHP Program provides quarterly regional metabolic clinics in Boise, Idaho Falls, and Cour d'Alene/Lewiston. Dr. Cary Harding continues to conduct these clinics, with the support of his Metabolic Nutritionist, Martha Duffy. //2008//

The MCH research analyst, Greg Seganos, and the MCH special Projects Coordinator, Traci Berreth, have recently completed the publication of the Bureau of Clinical and Preventive Services outcome performance measures. This document will be updated quarterly and will provide a method for the MCH programs to monitor performance on a statewide basis as well as provide information to the Department's administration in regard to the Bureau's contribution to the Department's goal of improving health status.

/2008/ MCH Director, Dieuwke A. Spencer, and MCH research analyst, Ward Ballard, will continue to compile and analyze outcome performance measures quarterly and annually. //2008//

The Idaho Fit Kids Project is a year long pilot project focusing on the use of BMI as a predictor of risk for overweight in children and providing families with helpful tips on health. The Division of Health contracted with the District Health Departments in the state to provide training to pediatrician and family practice offices in their service area. The trainings include factual information on BMI, ideas for incorporating BMI into practice and how to provide parents with guidance related to their child's healthy growth.
Each Health District has been contracted to provide up to 25 trainings between March 1, 2005 and October 31, 2005. The Division of Health provided training to the Health Districts regarding this project in January 2005.

Through the trainings provided by the Health Districts, physician offices will receive "Idaho Fit Kids" handouts for patients, CDC growth grids, and a card for families to mail to the Department of Health and Welfare if they would like to receive more information related to healthy growth. The families who return the request for information card will receive a series of 6 newsletters in the mail from the Division of Health. The newsletters will contain tips on eating healthy and activity.

To date, the Health Districts have trained over 30 physician offices in the state.

Evaluation will take place in January 2006 and will include:

1. Chart review of physician offices which received training to measure whether or not BMI was assessed.

2. A written survey will be mailed to families who requested more information for the purpose of determining if they found the information helpful.

3. Physician offices will be asked to complete a brief survey during January 2006 related to the project.

/2007/ Through the Idaho Fit Kids Project the Health Districts trained 141 physician offices in the state. 125 families requested additional information through a series of newsletters. Evaluation is currently underway and will be completed by the end of calendar year 2006.

1. Chart reviews are being conducted in the physician offices which received the training to measure whether or not BMI was assessed.
2. Physician offices are being asked a few questions regarding the project using an interview format. This interview is occurring at the same time of the chart review
3. Written surveys are being distributed to the families who requested more information for the purpose of determining if they found the information helpful.

Follow-up projects will be considered based on the project evaluation results. //2007//

The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 34,190 children grades 1-6 in 2004. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 51,747.

/2007/ The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 33,754 children grades 1-6 in 2005. Classroom education, dental surveys and teacher in-service training bring the total number of individuals served through school-based interventions to 56,795. //2007//

The MCH Oral Health Program continues to fund early childhood caries (ECC) prevention and fluoride varnish projects for WIC clients, Head Start children, and children who are Medicaid/CHIP eligible. During 2005, 13,323 children received preventive dental services, including 3,020 who received fluoride varnish applications, and 7,382 parents, teachers, dental and medical health professionals served through education and community outreach efforts.

The State Oral Health Collaborative Systems (SOHCS) Grant to integrate oral health with well child care was implemented during 2005 in southwest Idaho. Trainings in early childhood caries prevention and fluoride varnish application were provided to 36 dental and 93 medical professionals, including the Family Practice Residency of Idaho faculty, residents and nursing staff; St. Luke's Cystic Fibrosis Clinic nurses; the Ada Canyon Medical Education Consortium; health district immunization clinic nurses; and private practice dentists, physicians and staff. The project also included media outreach to an estimated 51,120 women age 18-34 years through public service announcements developed in partnership with Idaho Oral Health Alliance

members.

The Oral Health Program helped convene the Idaho Head Start Oral Health Forum in November 2004. Forum follow-up included development of an Idaho Head Start Oral Health Action Plan and motivational interview trainings with a focus on oral health, presented by Dr. Philip Weinstein, University of Washington, during September 2005. The motivational interview trainings were held in six population areas of the state and were attended by 244 Head Start, WIC and district dental staff. A smile survey of Idaho Head Start children is currently underway.

The 2005 Idaho State Smile Survey collected oral health data on 6,300 kindergarten, third and sixth grade students.

G. Technical Assistance

The Idaho Oral Health Program may request technical assistance to support the prenatal oral health project that is currently in the planning stages for implementation in FY 2006.

The goal of the project is to integrate oral health with prenatal care. The target population is pregnant women, particularly those served through the Medicaid Program. The Idaho Medicaid Program pays for approximately 40% of all deliveries. Efforts will be made to engage both medical and dental care providers in the effort. Project partners will include the Medicaid Healthy Connections Program, the District WIC and Oral Health Programs, as well as representatives of professional and community organizations with an interest in maternal and child health.

Project objectives are to increase awareness of the link between oral health and birth outcomes and increase access to periodontal care that can improve pregnancy outcomes. Medicaid data on dental access and costs associated with deliveries and preterm births will serve as a baseline for project evaluation.

Plans are to bring together key stakeholders for a brainstorming session to present the project proposal, get input, and form a state leadership team. If a technical assistance request is submitted, it will be to bring in a consultant to participate in the brainstorming session, advise the leadership team, and to provide continuing education for project partners on the science linking oral health to birth outcomes and the safety of providing dental services during pregnancy. We anticipate both state and district level trainings could require technical assistance.

/2008/ The Children's Special Health Program (CSHP) is unsure how to approach trying to impact Performance Measure #3 (Medical Home), and would appriciate some technical assistance on the subject. //2008//

V. Budget Narrative

A. Expenditures

Annual Expenditures

For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and related notes.

Funds used for state match during federal fiscal year 2007 are from the Immunization Program. State general fund in the amount of $1,865,748 were used to purchase vaccine for children. This funding commitment allows the state to maintain universal status where all children regardless of income or insurance status have access to free vaccine. The other portion of MCH grant match comes from local Immunization Program funds in the amount of $638,802. These funds are used for immunization education and outreach and for conducting local immunization clinics.

The expenditures in FFY 07 that were directed to Pregnant Women including 25% of the MCH administrative budget ($41,440), Pregnancy Risk Assessment Tracking system ($52,662), 25% of the Office of Epidemiology and Food Protection MCH budget ($61,205), 20% of the Reproductive Health MCH budget ($152,281), and 25% of the Idaho CareLine MCH budget ($11,487).

Funds used in FFY 07 for Infants < 1 Year Old included 25% of the MCH administrative budget ($41,440), 25% of the Office of Epidemiology and Food Protection MCH budget ($61,205), 25% of the Idaho CareLine MCH budget ($11,487), 50% of the Immunization Program state and local funds used for block grant match ($1,252,275), and newborn hearing screening ($13,618).

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($41,440), 25% of the Office of Epidemiology and Food Protection MCH budget ($61,205), 25% of the Idaho CareLine MCH budget ($11,487), 50% of the Immunization Program state and local funds used for block grant match ($1,252,275), the Oral Health Program ($529,058), and 40% of the MCH budget for Reproductive Health ($304,564).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget ($41,439), 25% of the Office of Epidemiology and Food Protection MCH budget ($61,203), 25% of the Idaho CareLine MCH budget ($11,487), the Genetics Program ($243,346) and the Children's Special Health Program ($992,430).

40% or $304,564 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age. And $260,558 in indirects was included in expenditures for the Administrative budget.

FFY 07 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the Genetics Program budget ($219,011), the Reproductive Health Program Budget ($761,409) and the Children's Special Health Program budget ($992,430). The two programs included under enabling services was the Idaho CareLine ($45,948) and 10% ($2,068) of the MCH money supporting the STD program. Programs included in the Population-Based Services category were Oral Health ($529,058), Immunizations ($2,504,550 - state and local match), and Newborn Hearing Screening ($13,618).

Programs included under infrastructure Building Services included: MCH Administration ($165,759), Pregnancy Risk Assessment Tracking System ($52,662), Office of Epidemiology and Food Protection ($244,818), 10% of the Genetics Program ($24,335), and the indirect budget ($260,558).

Total reported MCH expenditures for Idaho during FFY 07 are $5,843,950.

B. Budget

Budget Narrative

To meet the match requirement the state will be utilizing $2,150,381 in state general fund and $379,496 in local funds.

The priority areas for Idaho are children with special health care needs, reproductive health for young women, oral health of children and women of child bearing age, epidemiology services and genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. In fact, those two programs alone account for 39% of the block grant funds. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Epidemiology.

An area we had focused additional funding on was Idaho's Pregnancy Risk Assessment Survey. Data from previous years provided an overview of perinatal issues statewide, but by increasing the sample size we are now able to identify trends in specific areas of the state. We will begin using this valuable data to guide program direction and project development.

A good working relationship continues to grow between Idaho Perinatal Project team and midwives in the state. Based on the results of the birth complications survey, the Project is planning to move forward with seeking legislation to ensure the best possible birth outcomes for all infants born in Idaho.

The Idaho Perinatal Oral Health project has been well received. This project targets primary care providers, dentists and others professionals in the community to increase awareness on the importance of a dental visit during the second trimester. The project will also work toward improving the awareness among females of reproductive age about the importance of dental care during pregnancy. $50,000 has been allocated to this project, and it will be administered through the oral health program. In past year a statewide media campaign and educational pieces were produced. The goal is to develop a referral infrastructure within communities that can be sustained without continued MCH funding.

This past year the WIC Program is completed a project to assist employers in becoming breastfeeding friendly by supporting mothers who are nursing. This project was a train-the-trainer format with breastfeeding coalitions around the state in an effort to increase local level expertise. The estimated cost of the project was $30,000. Total cost was approximately $10,000. The lower than expected cost was because not all councils participated. Three of the 7 councils participated as well as one health insurance company. This project has well received and garnered some positive press coverage.

The above mentioned projects are directly intended to create systems change. This allows the federal MCH dollars to be invested for only a short period of time with long term benefits to the overall system caring for pregnant women and children.

One area that the State has made progress on over the past year is transitioning Idaho's Children Special Health Program away from being primarily an insurance plan to focusing on care coordination for the uninsured and ensuring reasonable access to specialty care throughout the state. This is the first step to a longer term plan of ensuring access to care and health care system navigation for all families of children with special health care needs, not just those covered by Idaho's current program. CSHP has stayed within budget but has continued to have a difficult time with billing issues. The billing issues are being addressed and CSHP is now in a

good position as we move into Medicaid reform here in Idaho. Future projects will include the development of a CSHP website and database, program evaluation and continued work with various agencies, organizations and policy makers to develop the future role for MCH and CSHP.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.